BRITISH COLUMBIA

Ministry for Children and Families

MEASURING OUR SUCCESS

A Framework for Evaluating Population Outcomes

Second Edition
December 1999

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BRITISH COLUMBIA

Copies of this report may be accessed on the BC Government Ministry for Children and Families Website http:/www.mcf.gov.bc.ca/

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Measuring Our Success –
A Framework for Evaluating Population Outcomes
2nd Edition

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Executive Summary

Measuring Our Success was first published in October 1997. It contained over 100 indicators, which measure changes in the population outcomes of 16 objectives established by the Ministry for Children and Families (MCF) to achieve four population based goals.

The report shows overall improvements in over 64% of the ministry's objectives for population outcomes. By far, the majority of measures deal with the first two goals and this is related primarily to data availability. Of the Ministry's 16 objectives, two objectives are not included in the current report, because data are not yet being collected to measure the objectives. Of the 14 objectives for which data are available, the following results have occurred since the base year of 1995, the year immediately prior to the formation of MCF, 9 show overall improvement, 2 show overall decline and 3 show no overall discernible change.

For Goal #1, To Promote the Healthy Development of Children, Youth and Families, overall improvement was found for 5 of the 9 objectives:

- to optimize the health of babies at birth;
- to optimize the health and well-being of youth;
- to optimize the health and well-being of families with children;
- to reduce teen pregnancy and suicide by children and youth; and
- to reduce suicide by children and youth.

A decline was found for the two of the objectives:

- to optimize the health and well-being of children; and
- to reduce substance abuse by children and youth.

There were no discernible changes to the following two objectives:

- to optimize the health and well-being of infants and young children; and
- to reduce substance abuse by adults.

For Goal #2, To Protect Children and Youth from Abuse, Neglect and Harm overall improvement was noted for two of the three objectives:

- to reduce the abuse, neglect and harm of children and youth; and
- to reduce unintentional injury and premature death of children and youth.

No discernible change was found for the objective to reduce the occurrence and spread of vaccine preventable disease.

For Goal #3, To Support Adults with Developmental or Multiple Disabilities to Live Successfully and Participate in the Community there was improvement noted for the objective to increase the success of adults with developmental disabilities living in the community.

For Goal #4, To Protect Public Safety, improvement was found for the one objective, to reduce youth involvement in crime.

While no attempt is made to measure the statistical significance of these changes, and while the MCF is not the only agency affecting these changes, its policies, program funding, mandate and advocacy are geared to promote improvements for these measures.

Although the large majority of objectives have shown overall improvement there are areas that require further attention in order to improve the health and well-being of children and youth. There is a clear need for more emphasis to be placed on reducing substance abuse by children, youth and adults.

MCF will be soliciting feedback and response to this document from key stakeholders and will continue to review current research, in order to improve the *Framework*, for the future. The Ministry will use *Measuring Our Success* to guide and support planning and service delivery priorities.

MCF will also use this document to facilitate and promote collaborative strategic approaches with other ministries and levels of government, service partners, and other stakeholders to work to improve these population outcomes.

Introduction

The purpose of this document is to report provincial level performance on population-level outcomes. This document updates the information provided in *Measuring Our Success: A Framework for Evaluating Population Outcomes*, which was published in October 1997. The document provided the *Framework* for monitoring population outcomes of importance to the Ministry for Children and Families. In the *Framework*, the Ministry's four goals were translated into a set of outcome objectives, or desired results, and each outcome objective was accompanied by a series of measurable indicators. For each indicator, the initial report contained what was then the most recently available and accessible provincial data, as well as benchmark data from other jurisdictions for comparison purposes. The current document contains updated information on provincial performance since the initial report was prepared.

This second edition is divided into two sections. The first section, **Background**, provides the context of this report, information on its development and its use. The second section, **Performance Report**, contains the *Population Outcomes Framework* that consists of four goals with 14 outcome objectives, a total of 68 indicators with 114 measures. This section provides provincial measurements for each of the indicators for multiple years. Appendices and a feedback form are also included.

There were 13 indicators that appeared in the first edition of the *Framework*, that have been excluded in this edition because there were only limited or no data available to monitor performance over time. The decision to eliminate these indicators resulted in two outcome objectives that appeared in the initial *Framework*, having no data on which to report in this edition. Consequently, these outcome objectives are not presented in this report. However, they continue to be key objectives of MCF. The Ministry will continue to research potential indicators for these objectives for the next edition of the *Framework*.

Background

With the formation of the Ministry for Children and Families in September 1996, a commitment was made to performance management and measurement as a means of directing the organization to achieve its operational, compliance and financial objectives. Adoption of performance management is intended to improve accountability (i.e., the ability of the ministry to report on its responsibilities) and to improve the performance of the Ministry with respect to both its results and processes. A central feature of the performance management approach adopted by the Ministry is that it increases the focus on outcomes.

Outcomes refer to results. They include all of the possible consequences that arise from actions undertaken and can be intentional or unintentional. The outcomes of interest to the Ministry for Children and Families are related to individuals or are organizational in nature.

Outcomes for individuals are results for people and may be related to identifiable clients or to target populations. These outcomes tend to be focused on changes to health, well-being or status.

Organizational outcomes are results for the service delivery system and are often focused on changes to structure, processes, resource utilization, products, or amount of services delivered. These outcomes may mediate, or contribute to, individual outcomes.

While both categories of outcomes are important, human service-providing organizations have historically had difficulty identifying and measuring outcomes related to individuals. Thus, the Ministry has focused effort in this area. Such outcomes, after all, provide the rationale and focus for the Ministry's work.

The Ministry for Children and Families has articulated high level and broad goals based on its responsibilities for children, youth, and families, adults with developmental disabilities, adults with addiction issues, and youth justice clients. The four goals are:

- *to promote the healthy development of children, youth and families;*
- *to protect children and youth from abuse, neglect and harm;*
- *to support adults with developmental disabilities to live successfully and participate in the community;* and
- *public safety (from youth crime).*

These goals provide the vision of what is wanted for the identified population groups. They also provide the foundation for the articulation of desired outcomes at a population level.

In October 1997, the Ministry published its first edition of *Measuring Our Success: A Framework for Evaluating Population Outcomes*, which provided the framework for monitoring progress in relation to these broad goals. It articulates population-level outcomes of interest to the Ministry. Some of the measures used have subsequently been incorporated into the *Health Goals of British Columbia* published in December 1997 and used by the Provincial Health Officer in the study of the health of British Columbia's children in 1998. More recently, the federal government has now published a document, *Measuring Up: A Health Surveillance Update on Canadian Children and Youth (1999)*, that incorporates several of the measures used in the *Framework* document. But, the Canadian Council on Social Development, with it's pioneering publication; *The Progress of Canada's Children, 1996*, must be credited for bringing population outcomes for Canada's children into the public domain.

Description of *Population Outcomes Framework*

The *Populations Outcomes Framework* consists of:

- four goals, or general statements, of the desired results to be achieved;
- outcome objectives for each goal. The outcomes in the *Framework* are person-referenced and focus on health, well-being and status at a population level. The outcomes are phrased as objectives to indicate the desired direction of change;
- a set of indicators for each outcome objective. An indicator is a specific measure of an outcome. It is usually expressed here as a percent (number per 100 population) or rate (number per 1,000 or more population);
- provincial measures for each indicator. (The measures on each indicator is provided for the most recent year available and for up to four previous years); and,
- benchmark data for each indicator. Benchmark refers to the reference point on a given indicator against which provincial achievements can be compared. Ideally, benchmark data reflect a desired level of performance, determined by what has been achieved in a comparable jurisdiction (best practice); by what is thought to be reasonably achievable based on historical performance, research and evaluation findings; or as established by respected authorities with an operational interest in the outcomes (target).

The Purpose of the *Population Outcomes Framework*

The *Population Outcomes Framework* provides the background by which the Ministry can monitor progress in relation to its broadest and highest level goals. It is essentially a tracking mechanism. The monitoring of the outcomes and indicators contained in the *Population Outcomes Framework* allows the Ministry to track and report on:

- practices and behaviours indicative of positive health status and well-being; and,
- negative conditions that challenge the health status and well-being of children, youth, families, and of adults with addiction issues or developmental disabilities.

In addition, the monitoring of the outcomes and indicators allows the Ministry to assess the extent to which the collectivity of promotion, prevention and intervention services and strategic approaches undertaken in the province make a difference at the population level.

Clearly, the Ministry for Children and Families is not the sole influence on, nor stakeholder of, the goals upon which the *Population Outcomes Framework* rests. Individuals, families, communities, service providing agencies, other levels and departments of government, and others are equally significant players in achieving these goals. The Ministry has chosen to translate these goals into a series of outcome objectives accompanied by measurable indicators because:

- an articulated vision can build commitment;
- regular monitoring and reporting can increase awareness and understanding; and,
- it can guide our actions by identifying progress as well as areas requiring attention.

Thus, in the long run, the *Population Outcomes Framework* should support improvements in meaningful results for children, youth, and families, and for adults with addiction issues or developmental disabilities in BC.

It should be noted that the *Population Outcomes Framework* is not a vehicle to assess Ministry performance per se. Other vehicles (e.g. annual reports, audits, Children's Commission, Child and Family Advocate) are used to monitor, report and assess the Ministry's performance with regard to its resource utilization, service quality and effectiveness, legislated responsibilities, and desired organizational outcomes.

The Use of Indicators

The four goals are translated into a series of outcome objectives. Each outcome objective is accompanied by a set of indicators. An indicator can be considered an operationalization of an outcome. Indicators are used to measure the existence and direction of change and to assess whether observed changes are consistent with the achievement of desired outcomes and goals. The purpose of indicators is to flag particular areas that require attention. Their usefulness rests in changes over time against a standard (or benchmark) or comparisons among regions.

The *Framework* was developed from an analysis of similar work in other jurisdictions, a review of the evaluation and research literature, and consultation with selected community and professional stakeholders. In selecting indicators for each category, careful consideration has been given to ensure that the indicators are credible from a data perspective, meaningful for children and families, for adults with addiction issues or developmental disabilities; they are reliable over time; and that they capture the multi-dimensional nature of the outcomes. Where possible, the indicators measure results rather than service, emphasize positive rather than negative conditions, and use a mix of self-reported and administrative data.

Multiple indicators of each outcome are used in this report primarily to increase the likelihood of comprehensive measurement and interpretation. The outcomes identified here, for example, the health and well-being of youth, are multi-dimensional concepts. Therefore it would be difficult to find single indicators to validly and reliably capture all aspects of such concepts. The use of multiple indicators provides different perspectives, thus adding breadth to interpretation of performance with respect to an outcome. While the direction of change on indicators for any single outcome may corroborate one another, the direction may also differ, making it more challenging to interpret performance with regard to the outcome.

There are also at least two distinct advantages to using multiple indicators. First, multiple indicators improve our ability to monitor regularly and routinely. Due to the differences in the periods of the data collection or the timeliness of the analysis and publication of information, there are differences in the availability of the data for each indicator. With multiple indicators, however, the outcome can continue to be monitored. Second, the use of multiple indicators provides the opportunity for a more accurate view of the concept under study with the limitations and weaknesses of one indicator compensated for by the strengths of another.

Presentation of Indicators

Most indicators related to child health and well-being measure the condition of children among specific age groups. There are three main reasons for these age groupings:

1. they measure a condition or issue at the time in a child's life when it will have a significant impact on the child's development;
2. they maximize access to published data; and,
3. they reflect the ages for which the condition or issue is most prevalent.

Outcomes vs Indicators

An outcome is a result and an indicator is a measure for which we have information that helps quantify that result. The distinction between outcomes and indicators is not firm. Many of the indicators used in this report are outcomes for more narrowly defined organizations and programs, e.g. rate of low birth weight. Similarly, some of the outcome objectives could be viewed as indicators; for example, teen pregnancy could simply be an indicator of the health and well-being of youth.

The baseline data were established for 1995, or as close to that year as possible, so that conditions immediately prior to the Ministry for Children and Families being created could be established and changes measured following the Ministry's creation.

Considerations

Four considerations should be kept in mind while examining the provincial performance data and the benchmark data. First, there are cases where the provincial and benchmark data are not directly comparable as the data are derived from different sources that use slightly different measures or definitions. Second, differences between the provincial data and benchmark data are not necessarily statistically significant. Third, the attribution of cause and effect in changes cannot be readily established as many factors influence these changes, not all of which can be related to the programs or actions of the Ministry for Children and Families. Fourth, no attempt has been made to measure whether or not the changes since the baseline (primarily 1995) data were established are statistically significant.

Future Access to This Document

Measuring Our Success can be accessed on the Ministry website at http://www.mcf.gov.bc.ca/. Updates and revisions to the current information will be available there. To access the most current data regarding the Framework's indicators please check the site periodically.

Next Steps

In order to improve the quality and usefulness of the *Population Outcomes Framework* over time, the Ministry will do the following:

- host performance management forums to review this *Framework*. The forums will involve a broad mix of stakeholders because, in the end, results can only be achieved through the concerted action of all sectors of the community. Specifically, the forums will review the indicators selected, consider the latest research, and examine the role and validity of benchmarks. For some goals and objectives there are too many measures, for others, there are clearly too few, and still for others, none have yet been developed. It is worth noting that Oregon, which is a leader in the use of frameworks of this type, has reduced its number of indicators from 270 to 92;

- continue to review the research literature as frameworks of this nature need to remain dynamic and be modified as new, better information becomes available; and,

- solicit feedback from those who use the *Framework* so its usefulness can be improved.

From these processes, it is anticipated that better measures and indicators will be included in future releases of the report. There is also a commitment to use the *Population Outcomes Framework* within the Ministry to develop and produce regional reports, where such data are available. This document will also be used for overall performance management within the Ministry and moving towards allocating increased effort to those areas which either give the best returns, or which need substantial improvement.

Performance Report

This section contains the *Population Outcomes Framework*. It has four sub-sections, each corresponding to one of the Ministry's broad goals. Each sub-section contains a summary page, which describes the goal and highlights key findings. Indicators presented in italics are new to the second edition of *Measuring Our Success*.

Layout

For each goal, the outcome objectives and associated indicators are presented in separate tables. Provincial performance data and benchmark data are provided for each indicator. The provincial performance data presented here focus primarily on the 1995 through 1998 period as 1995 was the year prior to the creation of MCF. Shaded cells denote that data are unavailable for a given year due to the periodicity of data collection. Blank cells denote that data are collected but not yet available.

There is a column labeled "Trend" which indicates for each indicator the **general** direction of performance in the province with respect to each indicator. An upward arrow (🡅) indicates a general trend of improvement; a downward arrow (🡇) indicates a general trend of decline; while a diamond (◆) indicates that performance has more or less stayed the same or is inconclusive. It should be noted that levels of significance have not been determined for these trends.

Following each table are notes on the indicators - providing the data source, a detailed definition (where necessary), rationale, and nature of the benchmark. For more detailed notes regarding the specific indicators, refer to the referenced data source and/or source reports.

GOAL #1: To Promote the Healthy Development of Children, Youth and Families

The first goal, *to promote the healthy development of children, youth and families*, and its associated outcome objectives and indicators, looks at the healthy development and functioning of children from infancy through adolescence. It addresses the capacity of families to care for their children and flags critical issues that affect the health and well-being of youth. It also includes one outcome objective which focuses on substance abuse among adults.

This goal has 9 outcome objectives and a total of 76 measures on 53 indicators and sub-indicators. As noted in the introduction to this section, one outcome objective (*to optimize the health and well-being of children and youth with disabilities*) was dropped from the Framework due to the lack of data. The absence of data on children and youth with disabilities is a significant weakness. An additional weakness is that three of the outcome objectives have only one indicator which can be monitored annually. These outcome objectives relate to children in the 1-4 year age group; families with children; and suicide.

Highlights

For this section, of the 76 measures for which there was available trend information, the general trend in performance has been improving over the years reported for 39 (54%), no discernible change for 11 (15%), decline of 22 (31%) of the measures. There were 3 measures which trend data were not available at the publication date of this report. Overall, this suggests that we are moving in the desired direction in terms of the healthy development of children, youth and families in BC. Particularly, noteworthy, are the following trends:

Progress	Needing Improvement
Infants	
• Fewer infants are dying early in life with deaths due to preventable causes, such as SIDS. • The rate of two major threats to infant health (low birth weight and neural tube defects) has declined. • Expectant mothers report a decline in behaviours (drinking and smoking behaviours) which can be injurious to infant health.	
Young children	
• Young children appear to be developing well in BC with an increasing majority of preschoolers within or above the normal range of verbal and motor/social skills.	• There has been a slight increase in mortality rates among children 1-4 years of age. • An increasing percentage of children are showing signs of tooth decay at kindergarten. Performance has moved further away from the provincial target of 70%.

Progress	Needing Improvement
School age children and youth	
• The majority of children continue to look forward to going to school, an attitude which supports school achievement and participation. • On national tests on mathematics and language, an increasing number of 13 and 16 year old students in the province have scored in the three highest levels with respect to math knowledge and writing. • The high school completion rate has been generally stable. The completion rate of 72.2% is just above the national average.	• On national tests, fewer 13 and 16-year-old students have scored in the three highest levels of reading. • A decrease in percentage of parents who report their children get along with peers. • An increasing percentage of children exhibiting emotional distress
Youth issues	
• The teen pregnancy rate, teen birth rate and percent of sexually active females using contraception all improved indicating progress consistently for this outcome objective. • Deaths directly related to alcohol are rare among children and youth. Deaths in which alcohol is a factor are more common but have been decreasing. • Drug-induced deaths have also been declining among children and youth. When they do occur, it is typically among the 15-19 age group. • Suicide ideation and attempts have decreased among youth. • The suicide rate among youth and younger children has also decreased.	• An increased number of both male and female students reported smoking cigarettes on a regular basis and drinking alcohol.
Family	
• Slight improvements were seen along several dimensions of family functioning including how well the family works together; the existence of positive interactions between children and their parents; and the extent to which alcohol consumption is a not problem in the home environment.	• There has been a slight decline in the number of children whose parents report maintaining a non-violent home.
Adult addictions	
• There has been a decline in the rate of deaths indirectly related to alcohol (both directly and indirectly).	• An increasing percentage of the adult population is drinking more heavily. • Also, there has been an increasing number of drug induced deaths.

OUTCOME OBJECTIVE 1.1 To Optimize the Health of Babies at Birth

Indicator	1995	1996	1997	1998	Benchmark	Trend
1. Infant mortality rate	**5.9**	**5.0**	**4.55**	**4.03**	PEI **4.6** Japan, Sweden, Finland **4** 1995	↑
2. Rate of low birth weight babies	**52.61**	**51.26**	**52.27**	**50.14**	AB **59.3** 1995 Norway, Spain, Ireland, Finland **40** 1990-94	↑
3. Percentage of women who: (A) smoke or (B) drink during pregnancy	(A) **19.6%** (B) **15.9%** 1994	**(A) 18.3%** **(B) 12.5%**			(A) **21.3%** ON (B) **7.4%** NS 1994-95	(A) ↑ (B) ↑
4. Rate of newborns born with: (A) FAS (B) drug withdrawal syndrome or noxious influences transmitted to placenta	(A) **0.04** (B) **0.04**	(A) **0.04** (B) **0.09**	(A) **0.05** (B) **0.07**	(A) **0.00** (B) **0.12**	N/A	(A) ↕ (B) ↓
5. Rate of infants testing positive for HIV	**1.4**	**0.7**	**1.4**	**1.4**	Target **0**	◆
6. Rate of neural tube defects	**0.32**	**0.43**	**0.27**	**0.25**	England, Wales **0.13** 1996	↑
7. Rate of SIDs deaths	***1.0***	***0.5***	***0.5***	***0.3***	***0.23*** Japan 1996	↑

NOTES ON INDICATORS

1.1.1 INFANT MORTALITY

Definition
Deaths of infants less than 1 year old per 1,000 live births.

Source
BC Vital Statistics Agency; Statistics Canada; UNICEF, *State of the World's Children*.

Rationale
The infant mortality rate is a fundamental measure of health. It is associated with inadequate prenatal care, low birth weight, mother's age and mother's socioeconomic status.

Nature of Benchmark
Jurisdictional best performance - national/international.

1.1.2 LOW BIRTH WEIGHT BABIES

Definition
Infants born at less that 2,500 grams per 1,000 live births.

Source
BC Vital Statistics Agency; Alberta Vital Statistics; UNICEF, *State of the World's Children 1996.*

Rationale
The weight of a baby at birth is a key indicator of infant survival, health and development. Low birth weight babies are more likely to die during their first year. They are also more likely to experience birth defects, mental retardation, developmental delays, chronic respiratory ailments, and learning difficulties.

Nature of Benchmark
Jurisdictional best performance - national/international.

1.1.3 WOMEN WHO SMOKE OR DRINK DURING PREGNANCY

Definition
Number of mothers of children less than two years old smoking tobacco or consuming alcohol during all or part of their pregnancy expressed as a percentage of all mothers of children less than two years old surveyed.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
Mothers' use of tobacco and alcohol are prenatal behaviours that have been associated with risks to the infant. It has been determined that smoking during pregnancy leads to higher rates of low birth weight, stillbirth, prematurity and breathing problems at birth. Alcohol intake poses the greatest risk around the time of conception and during the first trimester. Consuming alcohol during pregnancy has been linked to health concerns such as fetal alcohol syndrome, low birth weight, spontaneous abortion, death of the infant around the time of birth and alcohol withdrawal in the newborn.

Nature of Benchmark
Jurisdictional best performance - national.

1.1.4 NEWBORNS DIAGNOSED WITH FAS/DRUG WITHDRAWAL SYNDROME OR NOXIOUS INFLUENCES

Definition
As indicated on Physician Notifications of Birth (PNOB) forwarded to the BC Vital Statistics Agency, expressed as a rate per 1000 live births.

Source
BC Vital Statistics Agency.

Rationale
FAS is one of the leading causes of reduced or delayed growth, birth defects and/or developmental delays in children. The effects of alcohol are 100% preventable. Both drug withdrawal and noxious influences can have immediate and long-term negative consequences on the development of a child. Many such consequences are determined by lifestyle factors of the mother.

Nature of Benchmark
Not yet developed.

1.1.5 INFANTS TESTING HIV POSITIVE

Definition
Infants testing HIV positive within 18 months of birth, expressed as a rate per 100 000.

Source
BC Centre for Disease Control Society; BC Provincial Health Officer.

Rationale
HIV antibodies, which indicate the presence of HIV, are transferred from mother to infant through the placenta. Data have shown that mother-to-child transmission can be prevented in many cases if HIV-positive women take AZT during pregnancy and during the birthing process.

Nature of Benchmark
Target.

1.1.6 NEURAL TUBE DEFECTS

Definition
Anomalies diagnosed at birth per 1,000 live and still births.

Source
BC Vital Statistics Agency; Health Canada, *Measuring Up, 1999.*

Rationale
The number of infants born with neural tube defects is a proxy measure of prenatal maternal health. Research suggests that at least 50% of neural tube defects can be prevented if women take sufficient amounts of folic acid (one of the B vitamins) prior to conception and during the first three months of pregnancy.

Nature of Benchmark
Target.

1.1.7 SIDS DEATHS

Definition
Number of confirmed deaths due to Sudden Infant Death Syndrome per 1 000 live births.

Source
BC Vital Statistics Agency; *World Health Organization*, World Health Annual Statistics.

Rationale
SIDS is a major source of infant mortality where the cause is unknown.

Nature of Benchmark
Jurisdictional best performance - international.

OUTCOME OBJECTIVE 1.2 To Optimize the Health and Well-Being of Infants and Young Children

Indicator	1995	1996	1997	1998	Benchmark	Trend
1. Mortality rate for children age 1-4 years	**0.16**	**0.24**	**0.20**	**0.21**	P.E.I. **0.1** 1994	↓
2. Percentage of mothers who: (A) breast-feed (B) breast-feed more than 3 months	(A) **88.8%** (B) **59.6%** 1994	(A) **80.0%** (B) **66.3%**			SK (A) **91.3%** (B) **64.3%** 1994-95	(A) ↓ (B) ↑
3. Percentage of children with good verbal skills	**80.7%** 1994	**84.9%**			QU **89.5%** 1994-95	↑
4. Percentage of children with good motor and social skills	**87%** 1994	**87.2%**			P.E.I. **89.5%** 1994-95	◆

NOTES ON INDICATORS

1.2.1 CHILD MORTALITY, AGE 1 - 4 YEARS

Definition
Deaths per 1,000 children age 1 - 4 years of age.

Source
BC Vital Statistics Agency; Statistics Canada.

Rationale
Child mortality is a fundamental measure of health used by jurisdictions throughout the world. It can be associated with inadequate nutrition, lack of proper immunization, injury and/or abuse or neglect.

Nature of Benchmark
Jurisdictional best performance - national.

1.2.2 MOTHERS WHO BREAST-FEED

Definition
Number of mothers of children less than two years old who (A) breast-fed their most recent child and (B) breast-fed for at least 3 months expressed as a percentage of all mothers of children less than two years old surveyed.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
Breast-feeding has been linked with numerous positive benefits including improved bonding between mother and infant and better development of social behaviours. Breast milk contains the essential nutritional building blocks to sustain a rapidly growing infant. In addition, breast milk contains the mother's anti-bodies, which help to strengthen the infant's immune system.

Nature of Benchmark
Jurisdictional best performance - national.

1.2.3 YOUNG CHILDREN'S VERBAL SKILLS

Definition
Number of children age 4 - 5 years with verbal ability within or above the normal range of development expressed as a percentage of all children this age in the survey. Verbal ability was assessed using the revised *Peabody Picture Vocabulary Test (PPVT-R)*. Both English and French-speaking versions were used. The tests assess the number of words the subject understands and can be used for any age group, up to adults. The child looked at pictures on an easel and points to the picture that matches the words, which is read out by the interviewer. Both a raw score and a standardized score (factoring age for cross-child comparison) were assigned. In terms of the standardized score, the mean was 100 and the standard deviation was 15. Therefore, children who scored between 85 and 115 are considered to be within the normal range. Scores of 116 or more are considered above normal and while scores of less than 85 are considered below normal.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
Verbal ability is one of many measures of "school readiness". If children are equipped with the skills to learn such as verbal ability, learning in a school environment can build on and enhance these skills.

Nature of Benchmark
Jurisdictional best performance - national.

1.2.4 YOUNG CHILDREN'S MOTOR AND SOCIAL SKILLS

Definition
Number of children age 0 - 3 years with motor and social skills within or above the normal range of development expressed as a percentage of all children this age in the survey. The Motor and Social Development (MSD) scale was used to measure various dimensions of motor, social and cognitive development. Parents are asked to respond to 15 questions. Questions were altered depending on the age of the child. The results were combined into a single scale on which a score of 100 indicated normal development. Children who were within 15 points above or below 100 were considered to have normal motor, social and cognitive development. Those below 85 points displayed symptoms of delayed development, while those above 115 points displayed advanced development.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
This measure is an indicator of how well children are developing in comparison to their peers. Motor and social development are key components of a healthy, optimally functioning child.

Nature of Benchmark
Jurisdictional best performance - national.

OUTCOME OBJECTIVE 1.3 To Optimize the Health and Well-Being of Children

Indicator	1995	1996	1997	1998	Benchmark	Trend
1. Mortality rate for children age 5-14 years	**0.15**	**0.16**	**0.17**	**0.12**	Canada **0.2** 1995	↑
2. Percentage of children who are sad or depressed sometimes	**43.7%** 1994	**51.6%**			Canada **45.6%** 1996-97	↓
3. Percentage of children exhibiting emotional distress	**4.5%** 1994	**8.6%**			Canada **3%** 1994-95	↓
4. Percentage of children who get along with their; (A) mothers (B) fathers	(A) **76%** (B) **82%** 1994	(A) **86%** (B) **90%**			Canada (A) **85%** (B) **88%** 1996-97	↑ ↑
5. Percent children whose parents report harmonious parent/child relations	**85.3%** 1994	**83.5%**			Canada **87.6%** 1996-97	◆
6. Percent children who get along with their peers; (A) quite well (B) very well	(A) **54.7%** (B) **25.8%** 1994	(A) **48.8%** (B) **24.8%**			Canada (A) **48.4%** (B) **30.5%** 1996-97	↓ ◆
7. Percent children whose parents report their children get along with peers	**86.7%** 1994	**83.5%**			QU **92.9%** 1994-95	↓

Indicator	1995	1996	1997	1998	Benchmark	Trend
8. Percentage of children doing well in: (A) math problem solving (B) math knowledge	(A) **9%** (B) **26%** 1993		(A) **14%** (B) **27%**		(A) **11%** QU(French), AB (B) **43%** QU(French) 39% QU(English) 1993	(A) ↑ (B) ↑
9. Percentage of children doing well in: (A) reading (B) writing	(A) **42.3%** (B) **63.4%** 1994			(A) **38.7%** (B) **72.0%**	(A) **52%** QU(French) 46.5% AB (B) **67.7%** AB 1994	(A) ↓ (B) ↑
10. Percentage of : (A) girls (B) boys taking part in physical activity	(A) **72%** (B) **81%** 1992			(A) **72%** (B) **77%**	Canada (A) **71%** (B) **82%** 1993/94	(A) ◆ (B) ↓
11. Percentage of children who look forward to going to school	**86%** 1994	**86.1%**			ON, MA **89%** 1994/95	◆
12. Percentage of young children caries immune	**66.8%**	**67.5%**	**65.8%**	**63.6%**	Target **70%**	↓

NOTES ON INDICATORS

1.3.1 CHILD MORTALITY, AGE 5 - 14 YEARS

Definition
Deaths per 1,000 children age 5 - 14 years.

Source
BC Vital Statistics Agency; Statistics Canada.

Rationale
Child mortality is a fundamental measure of health. It can be associated with inadequate nutrition, lack of proper immunization, injury, suicide and/or with abuse or neglect.

Nature of Benchmark
Jurisdictional best performance - national.

1.3.2 CHILDREN WHO ARE SAD OR DEPRESSED

Definition
Number of children age 10 -11 years answering sometime or somewhat true" to the statement "I am unhappy, sad or depressed" expressed as a percentage of all children this age surveyed.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
How children feel is an important indicator of their health and well-being. Optimal health and well-being are impossible to achieve if a child is depressed. Mental well-being has been correlated with physical well-being and depression has been correlated with numerous adverse physical and mental symptoms.

Nature of Benchmark
National average.

1.3.3 CHILDREN EXPERIENCING EMOTIONAL DISTRESS

Definition
Number of children age 4 - 11 years whose parents rate them higher than mid-point on a 17-point emotional disorder scale expressed as a percentage of all children this age in the survey.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
Parental perceptions of their children's emotional state may have a bearing on their judgments regarding interactions with themselves and others. Conflicted perceptions between parents and children or misjudgments by parents can serve as an indicator of actual or potential risk, especially for families in crisis.

Nature of Benchmark
National average.

1.3.4 CHILDREN WHO GET ALONG WITH THEIR PARENTS

Definition
Number of children age 4-9 years answering "very well/no problem" or "quite well/hardly any problems" in response to the questions, "During the past 6 months, how well have you gotten along with your (A) mother and (B) father?" expressed as a percentage of all children this age surveyed.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
How well children get along with their parents is one way to determine the level of harmony within a family unit. It is widely believed that living in a happy, harmonious home-environment is conducive to the health and well-being of children.

Nature of Benchmark
National average.

1.3.5 CHILD/PARENT RELATIONS, PARENTAL PERCEPTIONS

Definition
Percentage distribution of children age 4 -11 years with parents answering "very well/no problem" or "quite well/hardly any problems" in response to the question, "During the past 6 months, how well has your child gotten along with his/her parents?" expressed as a percentage of all children this age surveyed.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
Parental perceptions of their children's emotional state may have a bearing on their judgments regarding interactions with themselves and others. Conflicted perceptions between parents and children or misjudgments by parents can serve as an indicator of actual or potential risk, especially for families in crisis.

Nature of Benchmark
Jurisdictional best performance - national.

1.3.6 CHILDREN WHO GET ALONG WITH THEIR PEERS

Definition
Number of children age 10 -11 years answering (A) "quite well" or (B) "very well" in response to the question, "During the past 6 months, how well have you gotten along with other kids, such as friends or classmates (excluding brothers or sisters)?" expressed as a percentage of all children this age surveyed.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
It is widely believed that a positive social network is particularly important to the emotional well-being of children.

Nature of Benchmark
National average.

1.3.7 CHILD/PEER RELATIONS, PARENTAL PERCEPTIONS

Definition
Percentage distribution of children age 4 -11 years with parents answering (A) "quite well" or (B) "very well" in response to the question, "During the past 6 months, how well has your child gotten along with his/her peers?" expressed as a percentage of all children this age surveyed.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
Parental perceptions of their children's emotional state may have a bearing on their judgments regarding interactions with themselves and others. Conflicted perceptions between parents and children or misjudgments by parents can serve as an indicator of actual or potential risk, especially for families in crisis.

Nature of Benchmark
Jurisdictional best performance - national.

1.3.8 PERFORMANCE LEVELS OF CHILDREN IN NATIONAL MATH TESTS

Definition
The number of randomly drawn 13 year olds who scored moderate to high levels (3 - 5) of achievement in mathematics content (knowledge) and problem-solving, divided by the total number of 13 year olds who participated in each test, expressed as a percent.

Source
Council of Ministers of Education, *Report on Mathematics Assessment.*

Rationale
Mathematics achievement is one component of academic performance which, in turn, measures the overall knowledge and capabilities of a student. Academic performance is highly correlated with nutrition, stable housing, family functioning, self-esteem, educational attainment of parents, and socioeconomic status. Academic performance is an indicator of a student's readiness to acquire more skills and knowledge, and thus to proceed to higher grade levels.

Nature of Benchmark
Jurisdictional best performance - national.

1.3.9 PERFORMANCE LEVELS OF CHILDREN IN NATIONAL READING AND WRITING TESTS

Definition
The number of 13 year olds who scored in the top three levels of achievement in reading and writing, divided by the total number of 13 year olds who participated in the test, expressed as a percent.

Source
Council of Ministers of Education, *Reading and Writing Assessment.*

Rationale
Reading and writing achievement is one component of academic performance which, in turn, measures the overall knowledge and capabilities of a student. Academic performance is highly correlated with nutrition, stable housing, family functioning, self-esteem, educational attainment of parents, and socioeconomic status. Academic performance is an indicator of a student's readiness to acquire more skills and knowledge, and thus to proceed to higher grade levels. The assessment of reading and writing achievement at the provincial and national level can provide a basis for examining social-class gradients and sex differences in academic performance.

Nature of Benchmark
Jurisdictional best performance - national.

1.3.10 CHILDREN TAKING PART IN PHYSICAL ACTIVITY

Definition
The number of male and female students in grade seven who answered three or more days in response to the question, "On how many of the past seven days did you exercise or participate in sports activities that made you sweat and breathe hard, such as basketball, jogging, fast dancing, swimming laps, tennis, fast bicycling or similar aerobic activities?", expressed as a percentage of all grade seven's who filled out the questionnaire.

Source
McCreary Centre Society, *Adolescent Health Survey* (AHS); WHO Europe Region, *The Health of Youth 1996*.

Rationale
Regular physical exercise increases a person's ability to perform daily activities with greater vigor, and may reduce the risk of specific health problems, including coronary heart disease, hypertension, non-insulin-dependent diabetes, colon cancer and depression, as well as premature mortality.

Nature of Benchmark
National average.

1.3.11 CHILDREN WHO LOOK FORWARD TO SCHOOL

Definition
Number of parents of children age 6 to 11 years who answered "often" or "always" in response to the question "With regard to how your child feels about school, how often does he/she look forward to going to school?" expressed as a percentage of all parents of children in this age group surveyed.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
The educational system and how children in Canada are performing in school is commanding a great deal of attention from parents, business, media and governments. However, if children dread going to school, this creates a stressful situation which may influence learning, as well as overall mental and physical health and well-being.

Nature of Benchmark
Jurisdictional best performance - national.

1.3.12 CHILDREN WHO ARE CARIES IMMUNE

Definition
Number of kindergarten age children who have never experienced tooth decay expressed as a percentage of all children screened.

Source
Dental Health Services, Ministry of Health.

Rationale
Dental disease is very common in children. It is associated with poor oral hygiene, inadequate nutrition and/or bad eating habits.

Nature of Benchmark
Target.

OUTCOME OBJECTIVE 1.4 To Optimize the Health and Well-Being of Youth

Indicator	1995	1996	1997	1998	Benchmark	Trend
1. Mortality rate for youth	**0.6**	**0.54**	**0.6**	**0.49**	NF **0.3** 1995	↑
2. Sexually transmitted disease rates for youth: (A) gonorrhea (B) chlamydia (C) syphilis, (D) PID	(A) **26.8** (B) **537.0** (C) **0.4** (D) **77.6**	(A) **20.9** (B) **468.5** (C) **0.0** (D) **86.4**	(A) **19.2** (B) **450.4** (C) **0.0** (D) **75.1**	(A) **21.9** (B) **459.7** (C) **1.9** (D)	Canada (A) **64** (B) **610.7** (C) **0.6** (D) **110.1** 1995	(A) ↑ (B) ↕ (C) ↓ (D) ◆
3. Rate of HIV infection among youth	**1.65**	**4.33**	**1.15**	**1.54**	Canada **1.5** 1995	↑
4. Rate of AIDS contraction among youth	***0.41***	***0.39***	***0.0***	***0.0***	*Canada* ***0.1***	↑
5. Percentage of students in good health	**86%** 1992			**85%**	Canada **63%** 1990	↓
6. Percentage of children and youth with low self-esteem	**12.9%** 1994				Canada **11.8%** 1994	N/A
7. Percentage of youth doing well in: (A) math problem solving (B) math knowledge	(A) **25%** (B) **58%** 1993		(A) **31.2%** (B) **54.6%**		(A) **30%** QU (French) 29% AB (B) **73%** QU (French) 62% QU (English) 1993	(A) ↕ (B) ↓
8. Percentage of youth doing well in: (A) reading (B) writing	(A) **68.4%** (B) **78.5%** 1994			(A) **67.9%** (B) **83.6%**	(A) **80.4%** QU (French) **74.3%** AB (B) **84.4%** MA 1994	(A) ↓ (B) ↑
9. Percentage of students completing high school	**68.6%**	**71.5%**	**71.5%**	**72.2%**	Canada **70%** 1994	↑

Indicator	1995	1996	1997	1998	Benchmark	Trend
10. Percentage of: (A) girls (B) boys taking part in physical activity	(A) **65%** (B) **82%** 1992			(A) **69%** (B) **81%**	Canada (A) **56%** (B) **81%** 1993/94	(A) ↕ (B) ↓
11. Percentage of: (A) girls (B) boys who wish to lose weight	(A) **58%** (B) **17%** 1992			(A) **57%** (B) **18%**	Canada (A) **48%** (B) **22%** 1993/94	(A) ↕ (B) ↓

NOTES ON INDICATORS

1.4.1 YOUTH MORTALITY

Definition
Deaths per 1,000 youth age 15 - 19 years.

Source
BC Vital Statistics Agency; Statistics Canada.

Rationale
Youth mortality is a fundamental measure of health. It can be associated with inadequate nutrition, injury, depression and/or with abuse or neglect.

Nature of Benchmark
Jurisdictional best performance - national.

1.4.2 SEXUALLY TRANSMITTED DISEASE AMONG YOUTH

Definition
Reports per 100,000 youth age 15-19 years.

Source
BC Centre for Disease Control Society, *Sexually Transmitted Disease Control: Annual Report; Canadian Journal of Human Sexuality*, 6(2) (1997).

Rationale
This indicator is a measure of health status as well as adolescent risk-taking behaviour that can lead to poor health outcomes. Indirectly, it is a measure of youth access to sexual health education and birth control methods that protect against sexually transmitted diseases. The sexually transmitted disease rate is also a marker for potential HIV infection. Sexually transmitted diseases are preventable and curable.

Nature of Benchmark
National average.

1.4.3 HIV INFECTION AMONG YOUTH

Definition
Initial positive tests per 100,000 youth age 15-19 years. There are several caveats to the data: 1) the data represent only individuals who have been tested for HIV; 2) the total number of HIV positive tests is not equal to the total number of HIV positive individuals as there may be some duplicate testing; 3) the data are not incidence reports as an HIV positive test report may be from a person who is at any stage in the HIV disease process; 4) it is not correct to add the number of HIV positive tests and the reported AIDS cases to determine the total number of people who are HIV positive and living with AIDS as the same report could be included in both databases; 5) there may be some degree of under-reporting as there is a time delay between the time the HIV test is conducted and when a positive test result reaches Health Canada.

Source
BC Centre for Disease Control Society; Health Canada, *HIV in Canada*.

Rationale
HIV/AIDS continues to be an epidemic of concern in this country. In Vancouver, AIDS is the leading cause of Potential Years of Life Lost. Each new case of HIV infection translates into $100,000 to $150,000 direct costs to the health care system (Provincial Health Officer's Annual Report 1996). HIV infection influences life expectancy and quality of life. HIV infection is highly correlated with personal risk behaviours such as injection drug use and unprotected sex. HIV surveillance is essential to monitor more closely the HIV/AIDS epidemic in Canada as HIV testing and diagnosis is usually closer to the time of infection than an AIDS diagnosis.

Nature of Benchmark
National rates.

1.4.4 AIDS CONTRACTION AMONG YOUTH

Definition
Incidence of first diagnosis per 1,000 youth age 15-19 years.

Source
BC Centre for Disease Control Society, STD/AIDS Control, Health Canada, Bureau of HIV/AIDS and STDs.

Rationale
HIV/AIDS continues to be an epidemic of concern in this country. In Vancouver, AIDS is the leading cause of Potential Years of Life Lost. Each new case of HIV infection translates into $100,000 to $150,000 direct costs to the health care system (Provincial Health Officer's Annual Report 1996). HIV/AIDS influences life expectancy and quality of life. Data suggest that, based on the evidence that diagnosis for AIDS increases drastically in early adulthood, AIDS contraction is associated with high-risk behaviours common in adolescence. This can be attributed to the relatively long period between HIV infection and the onset of AIDS symptoms.

Nature of Benchmark
National total.

1.4.5 STUDENTS WITH GOOD HEALTH STATUS

Definition
The number of students in grades 10 through 12 who answered "excellent" or "very good" (as opposed to "good", "fair" or "poor") to the question; "In general, how would you describe your health?", expressed as a percentage of all students in grades 10 through 12 who answered the question.

Source
McCreary Centre Society, *Adolescent Health Survey* (AHS); Canada's Health Promotion Survey.

Rationale
How people perceive their own health is an important measure to consider when assessing the health of an individual or a population. A number of studies have shown that self-rated health is indicative of both physical health and social well-being.

Nature of Benchmark
National average.

1.4.6 CHILDREN AND YOUTH WITH LOW SELF-ESTEEM

Definition
The number of respondents 12-19 years who scored 16 or less on a single scale of self-esteem expressed as a percentage of all respondents in the 12-19 age group. The scale has a range of 0-24 with higher scores indicating greater self-esteem.

Source
National Population Health Survey (NPHS).

Rationale
Young people, particularly young females, are seen to be most at risk in terms of emotional health. Among youth, stress and feelings of loneliness are common. The literature suggests that a positive sense of self influences one's ability to participate in and achieve desirable things in life and even one's immune and endocrine systems.

Nature of Benchmark
National average.

1.4.7 PERFORMANCE LEVELS OF YOUTH ON NATIONAL MATH TESTS

Definition
The number of 16 year olds who scored in the top three of five levels of achievement in mathematics content and problem-solving, divided by the total number of 16 year olds who participated in each test, expressed as a percent.

Source
Council of Ministers of Education. *Report on Mathematics Assessment.*

Rationale
Mathematics achievement is one component of academic performance which, in turn, measures the overall knowledge and capabilities of a student. Academic performance is highly correlated with nutrition, stable housing, family functioning, self-esteem, educational attainment of parents, and socioeconomic status. Academic performance is an indicator of a student's readiness to acquire more skills and knowledge, and thus to proceed to higher grade levels.

Nature of Benchmark
Jurisdictional best performance - national.

1.4.8 PERFORMANCE LEVELS OF YOUTH ON NATIONAL READING AND WRITING TESTS

Definition
The number of 16 year olds who scored in the top three of five levels of achievement in reading and writing, divided by the total number of 16 year olds who participated in each test, expressed as a percent.

Source
Council of Ministers of Education. *Reading and Writing Assessment.*

Rationale
Reading and writing achievement is one component of academic performance which, in turn, measures the overall knowledge and capabilities of a student. Academic performance is highly correlated with nutrition, stable housing, family functioning, self-esteem, educational attainment of parents, and socioeconomic status. Academic performance is an indicator of a student's readiness to acquire more skills and knowledge, and thus to proceed to higher grade levels. The assessment of reading and writing achievement at the provincial and national level can provide a basis for examining social-class gradients and sex differences in academic performance.

Nature of Benchmark
Jurisdictional best performance - national.

1.4.9 STUDENTS WHO COMPLETE HIGH SCHOOL

Definition
The number of current Grade 12 students expressed as a percentage of the number of Grade 8 students 4 years earlier.

Source
BC Ministry of Education; Canadian Council on Social Development, *The Progress of Canada's Children 1996.*

Rationale
Graduating from high school is critical for obtaining post-secondary education. Youth who do not complete high school face enormous challenges in achieving financial success. Over their lifetime, high school dropouts will earn significantly less money and face much higher rates of unemployment than high school graduates and college or university graduates.

Nature of Benchmark
National average.

1.A.5d Youth Taking Part in Physical Activity

Definition
The number of male and female students age 15 years who answered three or more days in response to the question, "On how many of the past seven days did you exercise or participate in sports activities that made you sweat and breathe hard, such as basketball, jogging, fast dancing, swimming laps, tennis, fast bicycling or similar aerobic activities?", expressed as a percentage of all 15 year old male/female students who filled out the questionnaire.

Source
McCreary Centre Society, *Adolescent Health Survey* (AHS); WHO Europe Region, *The Health of Youth 1996*.

Rationale
Regular physical exercise increases a person's ability to perform daily activities with greater vigor, and may reduce the risk of specific health problems, including coronary heart disease, hypertension, non-insulin-dependent diabetes, colon cancer and depression, as well as all-cause mortality rates.

Nature of Benchmark
National average.

1.A.5e Students Who Report Trying to Lose Weight

Definition
Number of 15 year old girls and boys trying to lose weight expressed as a percentage of all those in the same age category surveyed.

Source
McCreary Centre Society, *Adolescent Health Survey* (AHS); WHO Europe Region, *The Health of Youth 1996*.

Rationale
This measure is an indicator of the extent to which youth are dissatisfied with their body image and are at risk of adopting unhealthy approaches to weight control. The overemphasis on thinness during adolescence may contribute to eating disorders such as anorexia nervosa and bulimia.

Nature of Benchmark
National average.

OUTCOME OBJECTIVE 1.5 To Optimize the Health and Well-Being of Families with Children

Indicator	1995	1996	1997	1998	Benchmark	Trend
1. Percentage of children living in healthy functioning families	**92.1%** 1994	**93.2%**			PEI **94%** 1994/95	↑
2. Percentage of parents with; (A) nurturing supports (B) emergency personal supports	(A) **94.7%** (B) **97.2%** 1994				(A) **97.2%** SK (B) **99%** SK, NS 1994/95	N/A
3. Percentage of children whose parents have positive interactions with them	**86.7%** 1994	**91.5%**			NS, NB **90.2%** 1994/95	↑
4. Percentage of children whose parents practice consistent parenting	**71.5%** 1994	**74.4%**			AB **75.7%** 1994/95	↑
5. Percentage of children whose parents indicate alcohol consumption is a domestic problem	**8.1%** 1994	**5.1%**			ON **5.6%** 1994/95	↑
6. Percentage of children whose parents maintain a non-violent home	**92.2%** 1994	**90.8%**			NF **94.8%** 1994/95	↓

NOTES ON INDICATORS

1.5.1 HEALTHY FUNCTIONING FAMILIES

Definition

Number of children age 0-11 years determined to be living in healthy functioning families expressed as a percentage of all children surveyed. Family functioning was determined using the same scale as the *Ontario Child Health Study* which asked parents of children age 0 to 11 years 12 questions focusing on six activities that reflected how well the family worked together; problem solving, communication, roles, emotional responsiveness, emotional involvement and behaviour control. Answers to the questions were combined and assigned a score between 0 and 35. This score was then compared to a scale according to which families who scored between 0 and 14 were considered "healthy functioning" and over 15 was considered "dysfunctional".

Source

National Longitudinal Survey of Children and Youth (NLSCY).

Rationale

The family unit is the primary environment for young children. As such, the quality of this environment (e.g. family functioning) will have major effects on the health and well being of all family members. The Ontario Child Health Study found a significant association between family dysfunction and mental health problems among children. Those children who demonstrated problems in their relationships were more likely to live in families that were classified as dysfunctional than in families considered functional.

Nature of Benchmark
Jurisdictional best performance - national.

1.5.2 SOCIAL SUPPORT FOR PARENTS

Definition
Number of parents of children age 0-11 years who "agreed" or "strongly agreed" with a number of statements regarding social supports expressed as a percentage of all parents surveyed.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
Social support assists parents to cope with the everyday stresses of raising children and may help to defuse problems before they reach crisis proportions. A parent's social support system can make child rearing easier.

Nature of Benchmark
Jurisdictional best performance - national.

1.5.3 PARENTS WHO HAVE 'POSITIVE INTERACTIONS' WITH THEIR CHILDREN

Definition
Number of children age 2-11 years whose parents were rated as practicing "positive interactions" with them expressed as a percentage of all children surveyed. Parents were asked several questions concerning their interaction with their children. Results of the questions were combined to produce a standardized score ranging between 0 and 20, with 0 being "low positive interaction" and 20 being "high positive interaction". A score of 10 or more is reported here as indicative of positive interaction.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
Parental factors and the quality of interaction between parents and children have been found to contribute significantly to both positive and negative outcomes for children. The positive things parents do with their children have a major influence on their development. Parenting problems, on the other hand, have been recognized as critical to the development of childhood disorders, especially conduct disorders.

Nature of Benchmark
Jurisdictional best performance - national.

1.5.4 PARENTS WITH 'CONSISTENT' PARENTING PRACTICES

Definition
The number of parents of children age 2 to 11 years who were rated as practicing "consistent" parenting with their children expressed as a percentage of all parents of children of these ages who were surveyed. Parents were asked several questions concerning consistency of their parenting style. Results of the questions were combined to produce a standardized score ranging between 0 and 20, with 0 being "not consistent" and 20 being "very consistent". Consistent parenting practices are reported here as scores of 14 or more.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
Quality parenting, of which consistency is a component, is seen as a protective factor which can contribute to resilience in children. Protective factors provide a buffer, as well as a reservoir of resources, to deal effectively with stress; they therefore result in positive developmental outcomes such as school completion (NLSCY, 1996). Consistency of parenting practices is seen to help children understand the expectations their parents have of them. Parenting practices have been linked with children's formation of social relationships and with helping behaviour.

Nature of Benchmark
Jurisdictional best performance - national.

1.0.0 PARENTS WHO INDICATE THAT DRINKING IS A PROBLEM IN THE HOME

Definition
Number of children age 0-11 years whose parents "agreed" or "strongly agreed" that drinking is a source of tension or disagreement in the home expressed as a percentage of all children surveyed.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
When drinking is a source of tension or disagreement in the home, the home environment is negatively impacted. It is likely that at least one person in the home has a drinking problem. Children exposed to inappropriate alcohol consumption in the home are at increased risk of alcohol misuse themselves.

Nature of Benchmark
Jurisdictional best performance - national.

1.0.0 PARENTS WHO PROVIDE A NON-VIOLENT HOME

Definition
The inverse of the number of parent respondents of children age two to 11 years who indicated that their child sees adults or teenagers physically fighting or otherwise trying to hurt each other either seldom, sometimes or often, divided by all parents of children age two to 11 years who were surveyed, expressed as a percent.

Source
National Longitudinal Survey of Children and Youth (NLSCY).

Rationale
Exposure to violence in the home increases the likelihood that children will act out violently, both as children and adults. It may be associated with abuse and may negatively impact upon a child's self-esteem and sense of stability.

Nature of Benchmark
Jurisdictional best performance - national.

OUTCOME OBJECTIVE 1.6 To Reduce Teen Pregnancy

Indicator	1995	1996	1997	1998	Benchmark	Trend
1. Teen pregnancy rate	**49.3**	**48.8**	**45.3**		QU **29** 1991 Canada **42** 1992 Netherlands **11** 1991	↑
2. Teen birth rate	**22**	**19**	**18**	**17**	AB **77** Canada **24** United States **60** Netherlands **7** Japan **4** 1995	↑
3. Percent sexually active female youth using contraception	**76%** 1992			**78%**	Canada **74%** 1992	↑

NOTES ON INDICATORS

1.6.1 TEEN PREGNANCY RATE

Definition
Live births, stillbirths, induced abortions, and miscarriages requiring hospitalization per 1,000 females age 15-19 years.

Source
BC Vital Statistics Agency; Canadian Institute of Child Health, *Health of Canada's Children 1994;* Health Statistics Division, Statistics Canada; United Nations, *Demographics Yearbook 1991.*

Rationale
Teen pregnancy has far-reaching consequences for both the mother and child. Mothers face higher risks of complications in childbirth and their infants are at greater risk of prematurity, low birth weight, death in the first year of life, and developmental problems. Becoming pregnant at too early an age can distort a young woman's own development, limiting her education and life opportunities.

Nature of Benchmark
Jurisdictional best performance - national/ international and national average.

1.6.2 TEEN BIRTH RATE

Definition
Live births per 1,000 females age 15-19 years.

Source
BC Vital Statistics Agency; Alberta Municipal Affairs, *Vital Statistics Annual Review 1995*; UNICEF, *Progress of Nations 1998.*

Rationale
Teen parenthood is a predictor of future economic hardship for both parent and child. In addition to poor pregnancy outcomes, mothers who are children themselves are less likely to finish high school, and are far more likely to be poor and welfare dependent than those giving birth at later ages. Children born to teen mothers are more likely to be economically disadvantaged as children and adults.

Nature of Benchmark
Jurisdictional best performance - national/ international and national average.

1.8.2 SEXUALLY ACTIVE FEMALES USING CONTRACEPTION

Definition
Students were asked, "The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy?" The baseline figure is the number of females in grades seven through 12 who reported using some form of birth control (i.e. birth control pills, condoms or some other method excluding withdrawal) the last time they had sexual intercourse expressed as a percentage of all female students in grades seven through 12 who reported being sexually active. The benchmark is derived from a survey of 660 females 15 to 18 years living in three Canadian cities. Sexually active respondents were asked to indicate which types of birth control they used. The figure reported here is the inverse of the percentage of sexually active respondents who reported that they were not using any form of birth control.

Source
McCreary Centre Society, *Adolescent Health Survey* (AHS); Canadian Institute for Child Health, *The Health of Canada's Children 1994*.

Rationale
Unprotected sex can lead to sexually transmitted diseases and/or unintended pregnancy which can adversely affect the health and well being of teens and their babies.

Nature of Benchmark
National average.

OUTCOME OBJECTIVE 1.7 To Reduce Substance Abuse by Children and Youth

Indicator	1995	1996	1997	1998	Benchmark	Trend
1. Percentage of children and youth who smoke: (A) males (B) females	(A) **8%** (B) **10%** 1992			(A) **13%** (B) **19%**	SK **11.9** 1994	(A) ↓ (B) ↓
2. Percentage of students who drink alcohol regularly: (A) male (B) female	(A) **33%** (B) **32%** 1992			(A) **38%** (B) **38%**	Canada (A) **25%** (B) **19%** 1993/94	(A) ↓ (B) ↓
3. Rate of alcohol-related death among children and youth: (A) direct (B) indirect	(A) **0.0** (B) **3.1**	(A) **0.0** (B) **2.4**	(A) **0.2** (B) **1.57**	(A) **0.0** (B) **1.35**	(A) **0.0** NF, PEI, NS, MA, YK, NWT 1995	(A) ◆ (B) ↑
4. Rate of drug-induced death among children and youth	**1.23**	**1.8**	**0.98**	**0.97**	**0.0** Nfld, PEI, NS, NB, Yukon, NWT 1995	↑

NOTES ON INDICATORS

1.7.1 STUDENTS WHO SMOKE REGULARLY

Definition
Number of children and youth age 10-19 years who currently smoke on a regular basis (daily and non-daily) expressed as a percentage of the total population this age.

Source
McCreary Centre Society, *Adolescent Health Survey* (AHS); Health Canada Survey on Smoking in Canada, 1995.

Rationale
The effect of tobacco use on health is well known, yet experimentation with smoking is occurring at younger and younger ages and initiation of smoking now occurs almost entirely during the adolescent years. Therefore, preventing the initiation of smoking and other tobacco use remains an important priority.

Nature of Benchmark
Jurisdictional best performance - national.

1.7.2 STUDENTS WHO DRINK REGULARLY

Definition
The baseline data are the number of male and female students in grade 10 who reported that they had had at least one drink on three or more days in the past 30 days expressed as a percentage of all male/female grade 10 students who filled out the questionnaire. The benchmark reports the same information but for 15 year olds.

Source
McCreary Centre Society, *Adolescent Health Survey* (AHS); WHO Europe Region, *Health of Youth 1996.*

Rationale
Alcohol use by adolescents, particularly heavy use, has been conclusively linked to motor vehicle accidents and deaths, physical fights, destroyed property, academic problems, job difficulties, and troubles with law enforcement officials.

Nature of Benchmark
National average.

1.7.3 ALCOHOL-RELATED DEATHS OF CHILDREN AND YOUTH

Definition
Deaths per 100,000 children and youth age 10-19 years.

Source
BC Vital Statistics Agency; Statistics Canada.

Rationale
Death related to alcohol misuse is avoidable or at least premature. Alcohol-related death is associated with low self-esteem, health risk behaviour, alienation from home and school, and peer group affiliation.

Nature of Benchmark
Jurisdictional best performance - national.

1.7.4 DRUG-INDUCED DEATHS OF CHILDREN AND YOUTH

Definition
Deaths per 100,000 children and youth age 10-19 years.

Source
BC Vital Statistics Agency; Statistics Canada.

Rationale
Drug-induced deaths may be accidental, intentional and/or related to risk behaviours. In all cases, such deaths are considered premature. Drug-induced deaths are preventable.

Nature of Benchmark
Jurisdictional best performance - national.

OUTCOME OBJECTIVE 1.8 To Reduce Substance Abuse by Adults

Indicator	1995	1996	1997	1998	Benchmark	Trend
1. Rate of alcohol-related death among adults: (A) direct (B) indirect	(A) **15.0** (B) **61.0**	(A) **16.0** (B) **67.0**	(A) **14.13** (B) **51.02**	(A) **15.36** (B) **47.97**	(A) **9.3** NS 1995	(A) ◆ (B) ↑
2. Rate of drug induced death among adults	**10.3**	**12.7**	**13.5**	**17.61**	NF **0.7** 1995	↓
3. Percentage of adults who are regular heavy drinkers	**14%** 1994	**14%**			Canada **13.1%** 1996	◆

NOTES ON INDICATORS

1.8.1 ALCOHOL-RELATED DEATHS OF ADULTS

Definition
Deaths per 100,000 adults 20 years of age and over.

Source
BC Vital Statistics Agency; Statistics Canada.

Rationale
Death related to alcohol misuse is avoidable and/or premature.

Nature of Benchmark
Jurisdictional best performance - national.

1.8.2 DRUG-INDUCED DEATHS OF ADULTS

Definition
Deaths per 100,000 adults 20 years of age and over.

Source
BC Vital Statistics Agency; Statistics Canada.

Rationale
Drug-induced deaths may be accidental, intentional and/or related to risk behaviours. In all cases, such deaths are considered premature and preventable.

Nature of Benchmark
Jurisdictional best performance - national.

1.8.3 ADULTS WHO DRINK HEAVILY

Definition
Number of survey respondents 20 years of age and over who consumed five or more drinks on one occasion, 12 times or more in previous year, divided by the total number of survey respondents, expressed as a percent.

Source
National Population Health Survey.

Rationale
The misuse of alcohol places adults at risk of health, work and social problems and physical danger. Alcohol misuse is a contributing factor in family breakdown.

Nature of Benchmark
National average.

OUTCOME OBJECTIVE 1.9 To Reduce Suicide by Children and Youth

Indicator	1995	1996	1997	1998	Benchmark	Trend
1. Suicide rate for (A) children (B) youth	(A) **2.0** (B) **9.5**	(A) **1.2** (B) **6.1**	(A) **3.10** (B) **11.03**	(A) **0.39** (B) **5.79**	(A) **0.0** NF, PEI, YK, NWT (B) **0.0** YK 1995	(A) ↑ (B) ↑
2. Percentage of students attempting suicide	**7%** 1992			**7%**	N/A	◆
3. Percentage of students considering suicide (A) male (B) female	(A) **13%** (B) **20%** 1992			(A) **10%** (B) **17%**	(A) **4%** (B) **10%** QU 1992	(A) ↑ (B) ↑

NOTES ON INDICATORS

1.9.1 SUICIDE RATE FOR CHILDREN AND YOUTH

Definition
Deaths by suicide or self-inflicted injury per 100,000 (A) children age 10-14 years and (B) youth age 15-19 years.

Source
BC Vital Statistics Agency; Statistics Canada.

Rationale
Youth suicide is a fundamental measure of health. It is associated with sexual and emotional abuse, stress, running away from home, unplanned pregnancy, problems with sexual identity, cultural dislocation, unemployment and imprisonment. A high incidence of youth suicide reflects serious inadequacies in family and social supports, health and mental health services, and opportunities for success and well being.

Nature of Benchmark
Jurisdictional best performance - national.

1.9.2 ATTEMPTED SUICIDE BY CHILDREN AND YOUTH

Definition
The number of students in grades seven through 12 who reported that they had attempted suicide one or more times in the past 12 months, expressed as a percentage of all students in grades seven through 12 who filled out the questionnaire.

Source
McCreary Centre Society, *Adolescent Health Survey*.

Rationale
There has been a steady increase in suicide among youth in Canada over the last 25 years and it is now among the leading causes of death for adolescents. Although much has been written about suicide experiences, little is known about patterns and trends in the general youth population.

Nature of Benchmark
Not yet developed.

1.3.3 PERCENTAGE OF STUDENTS WHO CONSIDER SUICIDE

Definition
The number of males and females in grade eight who answered "yes" to the following question; "During the past 12 months, did you ever seriously consider attempting suicide?", expressed as a percentage of all female/male students in grades eight who filled out the questionnaire. The benchmark data report on basically the same question, however, respondents were 12 to 14 years of age and the time span for consideration was restricted to the past six months.

Source
McCreary Centre Society, *Adolescent Health Survey* (AHS); Quebec Child Mental Health Survey, 1992.

Rationale
There has been a steady increase in suicide among youth in Canada over the last 25 years and it is now among the leading causes of death for adolescents. Although much has been written about suicide experiences, little is known about patterns and trends in the general youth population.

Nature of Benchmark
Jurisdictional best performance - national.

GOAL #2: To Protect Children and Youth from Abuse, Neglect and Harm

The second goal, *to protect children and youth from abuse, neglect and harm*, focuses on what happens to children and youth when the family and society fail to provide adequately for them. The indicators for this goal track the incidence of abuse, neglect, exploitation, injury, premature death, and vaccine preventable diseases.

This goal has 3 outcome objectives and a total of 29 measures on 12 indicators.

Highlights

Generally the findings suggest that improvements have been made for a number of the measures. However, continued emphasis is required on this goal and a number of its associated outcome objectives. From the 29 measures presented, the general trend shows improvement for 13 (45%), no discernible change for 12 (41%) and decline on 4 (14%) of the measures.

Progress	Needing Improvement
• There was a slight decline in the number of students who reported having been physically and/or sexually abused and a decline in the rate of children and youth charged with prostitution related offences. • There have been decreasing rates of death and hospitalization due to unintentional injuries overall, particularly in the areas of transportation and home/residential injuries.	• An increasing number of children are being found to be in need of protection due to domestic abuse or neglect. • Overall, immunization rates are being maintained, but still are below the targets set for the province. This has been highlighted in the *Provincial Health Officer's Report, A Report on the Health of British Columbian's Provincial Health Officer's Annual Report 1998, Feature Report: Immunization, 1999*, which noted; "we can and must do better" with respect to immunization for infants and preschoolers (page 31). *

* The Ministry of Health has the legislative authority and is the lead ministry responsible for policy and program implementation.

OUTCOME OBJECTIVE 2.1 To Reduce Abuse, Neglect and Harm of Children and Youth

Indicator	1995	1996	1997	1998	Benchmark	Trend
1. Rate of domestic child abuse/neglect	3.4	4.9	4.8	5.6	N/A	↓
2. Percentage of students who have been physically and/or sexually abused; (A) male (B) female	(A) **15%** (B) **32%** 1992			(A) **14%** (B) **26%**	(A) **10%** Alaska (B) **25%** Minnesota	(A) ↑ (B) ↑
3. Rate of children and youth charged with prostitution-related offenses	.26	.10	.07	.05	Canada **10.7** 1995	↑

NOTES ON INDICATORS

2.1.1 RATE OF DOMESTIC CHILD ABUSE/NEGLECT

Definition
Confirmed reports (as defined under the *Child, Family and Community Service Act*) of abuse/neglect per 1,000 children and youth age 0-19 years.

Source
SWS/MIS statistical extract files, Ministry for Children and Families.

Rationale
Children need a safe and nurturing family environment for healthy development. This indicator suggests the extent to which children's security is threatened rather than protected by the adults on whom they are most dependent. Child abuse or neglect can result in physical harm, death or profound developmental and behavioural problems. Abused and neglected children may be at greater risk of delinquent behaviour and of mistreating their own children.

Nature of Benchmark
Not yet developed.

2.1.2 STUDENTS REPORTING A HISTORY OF PHYSICAL/SEXUAL ABUSE

Definition
Number of Grade 7-12 students indicating a history of physical and/or sexual abuse expressed as a percentage of all students surveyed.

Source
McCreary Centre Society, *Adolescent Health Survey* (AHS).

Rationale
Physical and sexual abuse have been linked to a variety of emotional difficulties than can affect people throughout life. Both physical and sexual abuse were found to be correlated with emotional distress and suicide ideation.

Nature of Benchmark
Jurisdictional best performance - international.

2.1.3 CHILDREN AND YOUTH INVOLVED IN PROSTITUTION

Definition
Charges for prostitution-related activity expressed as a rate per 1,000 children and youth age 12-17 years.

Source
Police Services Division, Ministry of Attorney-General; BC STATS, B.C.

Rationale
This indicator is a measure of the extent to which children and youth are adopting illegal, high risk life style behaviours. The lifestyle is frequently characterized by exploitation, violence, substance abuse and disease. Physical and sexual assaults are common. Studies show most adult prostitutes began in their teens. Prostitution is associated with low self-esteem, sexual and emotional abuse, running away from home, cultural dislocation, and unemployment. Involvement of children in prostitution reflects serious inadequacies in family and social supports. Child prostitution also reflects the inadequacies of legal protections available to vulnerable children and sanctions for adults who purchase sex from minors and/or procure children for the purposes of prostitution. The incidence of prostitution-related crimes is highly sensitive to changes in police enforcement practices.

Nature of Benchmark
National average.

OUTCOME OBJECTIVE 2.2 To Reduce the Occurrence and Spread of Vaccine Preventable Diseases

Indicator	1995	1996	1997	1998	1999	Benchmark	Trend
1. Percentage of 2 year olds immunized for:						Targets	
(A) diptheria/tetanus/ pertussis/polio/ haemophilus influenza b	(A) **83%**	(A) **81%**	(A) **81%**	(A) **83%**	(A) **84%**	(A) **97%**	(A) ◆
(B) measles, mumps, rubella	(B) **93%**	(B) **92%**	(B) **77%**	(B) **81%**	(B) **83%**	(B) **97%**	(B) ↓
2. Percentage of kindergarten children immunized for:						Targets	
(A) diphtheria/tetanus/ polio	(A) **93%**	(A) **92 %**	(A) **92%**	(A) **90%**	(A) **93%**	(A) **99%**	(A) ◆
(B) measles/mumps/ rubella	(B) **94%**	(B) **94%**	(B) **94%**	(B) **91%**	(B) **93%**	(B) **99%**	(B) ◆
3. Percentage of grade 6 students immunized for hepatitis B	**93%**	**93%**	**93%**	**92%**	**92%**	Target **97%**	◆
4. Rate of vaccine-preventable diseases for:						Target <1(A) - (C) **0** indigenous	
(A) diphtheria	(A) **0.0**	(A) **0.0**	(A) **0.0**	(A) **0.0**		cases	(A) ◆
(B) tetanus	(B) **0.0**	(B) **0.1**	(B) **0.1**	(B) **0.0**		(F) **0**	(B) ◆
(C) pertussis	(C) **12.0**	(C) **25.4**	(C) **18.5**	(C) **9.0**		indigenous	(C) ◆
(D) polio	(D) **0.0**	(D) **0.0**	(D) **0.0**	(D) **0.0**		cases by	(D) ◆
(E) haemophilus influenza B	(E) **0.2**	(E) **0.1**	(E) **0.1**	(E) **0.0**		(H) **0**	(E) ↑
(F) measles	(F) **0.4**	(F) **1.1**	(F) **7.0**	(F) **0.1**		indigenous	
(G) mumps	(G) **1.0**	(G) **1.3**	(G) **3.6**	(G) **0.5**		during	(F) ◆
(H) rubella	(H) **0.7**	(H) **0.5**	(H) **0.1**	(H) **0.1**		pregnancy	(G) ◆
(I) hepatitis (acute)	(I) **6.4**	(I) **6.0**	(I) **5.7**	(I) **4.8**		(I) **90%**	(H) ↑
(J) Hepatitis (chronic)	(J) **51.0**	(J) **52.4**	(J) **60.4**	(J) **60.6**		reduction in	(I) ↑
						children	(J) ↓

NOTES ON INDICATORS

2.2.1 IMMUNIZATION OF INFANTS

Definition

Percent of children who, by their second birthday, have completed the primary series for immunization, according to the Provincial Immunization Schedule. Rates are based on a one-month sample of children who were two years old in April of each year and for whom child health records (HLTH 182s) were available. Figures for 1995-1999 do not include Vancouver, Burnaby, North Shore or South Fraser Health Region (formerly Boundary Health Unit). Comparable data are not available for these regions. For Measles/Mumps/Rubella, a two-dose schedule was introduced in 1996.

Source

Ministry of Health, Public Health Nursing, B.C.

Rationale

Proper and timely immunization effectively protects children from a host of debilitating and sometimes deadly childhood diseases. It is also an indicator of parents' knowledge of health risks among young children, and the care and attention that parents pay their children.

Nature of Benchmark
Target - National

Definition
Percent of children who, by the end of kindergarten (school entry) year have received the appropriate number of vaccine doses, according to the Provincial Immunization Schedule. Figures are for the school year ending June each year.

Source
Ministry of Health, Public Health Nursing, B.C.

Rationale
Proper and timely immunization effectively protects children from a host of debilitating and sometimes deadly childhood diseases. These coverage levels indicate how well these children are protected from vaccine preventable diseases.

Nature of Benchmark
Target - National

Definition
Percent of children, who, by the end of grade six, have received three doses of hepatitis B vaccine during in-school immunization. Figures are for the school year ending June each year.

Source
Ministry of Health, Public Health Nursing, B.C.

Rationale
Proper and timely immunization effectively protects children from a host of debilitating and sometimes deadly childhood diseases. It is also an indicator of parents' knowledge of health risks among young children, and the care and attention that parents pay their children.

Nature of Benchmark
Target - National

Definition
Reported cases of vaccine-preventable diseases per 100,000 population. Acute cases of hepatitis B refer to persons recently infected and undetermined cases refer to cases in which blood-work could not determine whether infection was acute or chronic. Distinction between these two categories was not reported previous to 1997.

Source
BC Centre for Disease Control Society, Ministry of Health

Rationale
This indicator is a measure of how well B.C. is able to meet established targets for control of these preventable diseases.

Nature of Benchmark
Target - National

OUTCOME OBJECTIVE 2.3 To Reduce Unintentional Injury and Premature Death of Children and Youth

Indicator	1995	1996	1997	1998	Benchmark	Trend
1. Rate of; (A) death (B) hospitalization of children and youth due to unintentional injuries	(A) **14.3** (B) **921.6**	(A) **13.3** (B) **885.0**	(A) **12.1** (B) **819.6**	(A) **10.8** (B)	(A) **8.5** ON 1995 (B) **514.8** QU 1993	(A) ↑ (B) ↑
2. Rate of; (A) death (B) hospitalization of children and youth due to transportation-related injuries	(A) **9.2** (B) **213.4**	(A) **8.0** (B) **210.1**	(A) **8.4** (B) **181.1**	(A) **7.3** (B)	(A) **4.9** NF 1995 (B) **124.0** ON 1993	(A) ↑ (B) ↑
3. Rate of; (A) death (B) hospitalization of children and youth due to fire-related injuries	(A) **0.3** (B) **6.5**	(A) **0.1** (B) **7.7**	(A) **0.2** (B) **5.0**	(A) **0.7** (B)	(A) **0.0** PEI, NB, MB, YK, NT 1995 (B) **9.6** QU 1993	(A) ↓ (B) ↑
4 Rate of; (A) death (B) hospitalization of children and youth due to water-related injuries	(A) **0.8** (B) **4.2**	(A) **1.4** (B) **2.5**	(A) **0.7** (B) **3.8**	(A) **1.1**	(A) **0.0** PEI, YK, NWT 1995 (B) **1.2** NF 1993	(A) ◆ (B) ◆
5. Rate of; (A) death (B) hospitalization of children and youth due to home/ residential injuries	(A) **4.2** (B) **211.9**	(A) **2.1** (B) **199.7**	(A) **2.5** (B) **185.5**	(A) **1.7** (B)	N/A	(A) ↑ (B) ↑

NOTES ON INDICATORS

Definition
Deaths from unintentional injuries per 100,000 children and youth age 0-19 years, using PEOPLE 24, based on calendar year. Hospitalization cases, from unintended injuries per 100,000 children and youth age 0-19 years, using PEOPLE 23. The hospitalization data is fiscal year based i.e. for 1995, 1994/95 fiscal year data is reported.

Source
Office of Injury Prevention, Ministry of Health; BC Vital Statistics; Statistics Canada.

Rationale
Unintentional injury is the leading cause of death and injury for children over the age of one year. Up to 90% of unintentional injuries are preventable. To a great extent, the occurrence of injuries is determined by characteristics of the environment in which children live and play and the products that they use. This indicator is a measure of risk to children's health, and of

risk-taking behaviour, especially among youth. It is also a measure of the adequacy of a broad range of public health and accident prevention strategies, including public education, product development and use, community and road design, and prevention and treatment resources.

Nature of Benchmark
Jurisdictional best performance - National.

8.3.2 TRANSPORTATION-RELATED INJURIES AND DEATHS OF CHILDREN AND YOUTH

Definition
Deaths due to transportation-related injuries per 100,000 children and youth age 0-19 years, using PEOPLE 24, by calendar year. Hospitalization cases due to transportation-related injuries per 100,000 children and youth age 0-19 years, using PEOPLE 23. The hospitalization data is fiscal year based i.e. for 1995, 1994/95 fiscal year data is reported.

Source
Office of Injury Prevention, Ministry of Health; BC Vital Statistics; Statistics Canada.

Rationale
Motor vehicle accidents are the leading cause of injury-related death for children over the age of one year and the leading cause of injury-related hospitalization for youth age 15 - 19 years.

Nature of Benchmark
Jurisdictional best performance - National.

8.3.3 FIRE-RELATED INJURIES AND DEATHS OF CHILDREN AND YOUTH

Definition
Deaths due to fire-related injuries per 100,000 children and youth age 0-19 years, using PEOPLE 24, by calendar year. Hospitalization cases due to fire related injuries per 100,000 children and youth age 0-19 years, using PEOPLE 23. The hospitalization data is fiscal year based i.e. for 1995, 1994/95 fiscal year data is reported.

Source
Office of Injury Prevention, Ministry of Health; BC Vital Statistics; Statistics Canada.

Rationale
Unintentional injuries are the leading cause of death and injury for children and youth and they are 90% preventable.

Nature of Benchmark
Jurisdictional best performance - National.

8.3.4 WATER-RELATED INJURIES AND DEATHS OF CHILDREN AND YOUTH

Definition
Deaths due to water-related injuries per 100,000 children and youth age 0-19 years, using PEOPLE 24, by calendar year. Hospitalization cases due to water related injuries per 100,000 children and youth age 0-19 years, using PEOPLE 23. The hospitalization data is fiscal year based i.e. for 1995, 1994/95 fiscal year data is reported.**Source**
Office of Injury Prevention, Ministry of Health; BC Vital Statistics; Statistics Canada.

Rationale
Unintentional injuries are the leading cause of death and injury for children and youth and they are 90% preventable.

Nature of Benchmark
Jurisdictional best performance - National.

8.3.5 HOME OR RESIDENTIAL INJURIES AND DEATHS OF CHILDREN AND YOUTH

Definition
Deaths due to home/residential injuries per 100,000 children and youth age 0-19 years, using PEOPLE 24. Hospitalization cases due to home or residential related injuries per 100,000 children and youth age 0-19 years, using PEOPLE 23. The hospitalization data is fiscal year based i.e. for 1995, 1994/95 fiscal year data is reported.

Source
Office of Injury Prevention, Ministry of Health; BC Vital Statistics; Statistics Canada.

Rationale
Unintentional injuries are the leading cause of death and injury for children and youth and they are 90% preventable.

Nature of Benchmark
Not yet developed

GOAL #3: To Support Adults with Developmental or Multiple Disabilities to Live Successfully and Participate in the Community

The third goal is *to support adults with developmental or multiple disabilities to live successfully and participate in the community*. This goal addresses the unique situation of adults with developmental or multiple disabilities who are receiving services from the ministry. At present, there is no way to identify the entire population of adults with developmental or multiple disabilities in the province, and hence to measure progress in achieving outcomes for this group. As a result, the indicator for this goal are service-driven which creates a slight inconsistency in the *Framework*. Adults with developmental or multiple disabilities are included in the *Framework* to reflect the ministry's ongoing commitment to this group.

The lack of data on adults with developmental disabilities are significant weaknesses which needs to be addressed if this goal is to be adequately monitored. The one indicator used shows improvement.

Highlights

Progress	Needing Improvement
• The average length of time that adults with developmental disabilities are spending in tertiary care facilities has decreased suggesting that they are being well supported in the community.	

OUTCOME OBJECTIVE 3.1 To Increase Success of Adults With Developmental Disabilities Living in the Community

Indicator	1995	1996	1997	1998	Benchmark	Trend
1. Average length of stay of adults with developmental or multiple disabilities in tertiary care facilities (in months)		19	19	15	Target <6	↑

NOTES ON INDICATORS

3.1.1 AVERAGE LENGTH OF STAY OF ADULTS WITH DEVELOPMENTAL DISABILITIES IN TERTIARY CARE FACILITIES

Definition
Number of months of residence for all individuals admitted to Willow Clinic divided by the total number of individuals residing at Willow at that time. (Willow Clinic is the only tertiary level facility devoted to this client group)

Source
Willow Clinic, Ministry for Children and Families.

Rationale
Tertiary care is intended as a short term measure e.g., six months or less. When tertiary care evolves into the long-term residence of individuals, it is a measure of the inadequacy of community-based supports.

Nature of Benchmark
Target.

GOAL #4: To Protect Public Safety

The fourth goal, *to protect public safety*, explores the extent to which the safety and security of British Columbians is affected by youth involvement in criminal activity. This goal is specifically focused on youth 12 - 17 years as defined by the federal *Young Offender's Act*. The indicators for this goal are service-driven which creates a slight inconsistency in the *Framework*.

This goal has one outcome objective and eight measures on two indicators for which 4 (50%) of the measures show improvement, 1 (13%) show decline and 3 (37%) show no measurable change.

Progress	Areas of Concern
• Fewer youth are engaging in violent crimes. • Fewer youth are engaging in non-sexual assault. • Fewer youth are engaging in robbery.	• High percentages of youth who receive custody or community supervision dispositions have had previous contact with the criminal justice system.

OUTCOME OBJECTIVE 4.1 To Reduce Youth Involvement In Crime

Indicator	1995	1996	1997	1998	Benchmark	Trend
1. Rate of youth charged with;					(A) **4** QU	
(A) violent offenses	(A) **11.0**	(A) **10.5**	(A) **9.9**	(A) **9.2**	(B) **0.0** PEI., NF, NB, YK, NWT	(A) ↑
(B) murder/manslaughter	(B) **0.07**	(B) **0.04**	(B) **0.06**	(B) **0.02**	(C) **0.0** PEI, NF, NB, YK, NWT	(B) ↑
(C) attempted murder	(C) **0.02**	(C) **0.03**	(C) **0.06**	(C) **0.03**	(D)**1.6** AB	(C) ◆
(D) sexual offenses	(D) **0.75**	(D) **0.78**	(D) **0.76**	(D) **0.75**	(E) **4** QU	(D) ◆
(E) non-sexual assault	(E) **7.30**	(E) **7.39**	(E) **6.83**	(E) **6.66**	(F) **0.0** PEI	(E) ↑
(F) robbery	(F) **2.34**	(F) **2.06**	(F) **2.04**	(F) **1.62**	1993/94	(F) ↑
2. Percent youth who are repeat offenders admitted to;					Canada (A) **76%** 1993/94	
(A) custody	(A) **97%**	(A) **98%**	(A) **97%**	(A) **96%**		(A) ◆
(B) community supervision	(B) **61%**	(B) **61%**	(B) **69%**	(B) **72%**		(B) ↓

NOTES ON INDICATORS

4.1.1 YOUTH CHARGED WITH VIOLENT OFFENCES

Definition
Charges per 1,000 children and youth age 12-17 years.

Source
Police Services Division, *Youth Court Statistics,* Ministry of Attorney-General; BC STATS, BC.

Rationale
This indicator is a proxy for the extent to which youth are engaging in anti-social, violent and illegal activity. It is not a direct measure since the type of activity, social attitudes towards youth and crime, and police reporting techniques influence the nature and extent to which charges are laid. Violent youth crime is associated with poor community relationships, parental neglect, family dysfunction, criminality in the family, substance abuse by youth, and family poverty.

Nature of Benchmark
Jurisdictional best performance - national.

4.1.2 YOUTH WHO ARE REPEAT OFFENDERS

Definition
Baseline: Number of youths age 12-17 years who, at time of admission into the correctional system, had had previous contact with Corrections, expressed as a percentage of all children and youth admitted. Benchmark: Number of youth age 12-17 years with a previous conviction upon entering secure custody, expressed as a percentage of all children and youth sentenced to secure custody.

Source
Corrections Branch, Ministry of Attorney-General; *Juristat* 15 (16), Dec. 1995.

Rationale
This is a measure of the extent to which youth are adopting illegal lifestyles. It may also be viewed as a measure of Corrections Branch's success in diverting youth from illegal activity.

Nature of Benchmark
National average.

Appendices

The following five appendices contain the following;

Appendix A: This provides several key indicators which provide a context for understanding the health and well being of children and families in British Columbia.

Appendix B: This provides a brief summary of changes made since the first edition of *Measuring Our Success* in 1997. Fourteen measures have been dropped because no additional data were available for their measurement. Five new measures have been added.

Appendix C: This provides a summary of the data sources and reports used in developing the baseline, benchmark and annual measures.

Appendix D: This provides a listing of the thirty-five indicators for which annual data are available to allow regular updates.

Appendix E: This provides a listing of the forty-seven indicators which are available regionally, to allow regional comparisons.

APPENDIX A

Influences On Health And Well-Being

This section examines some of the social and economic influences that shape people's lives, such as demographics, famiiy structure, income, employment and housing. It can be used to provide some context for the preceding Performance Report within which a better understanding of the situations of children and families in British Columbia can be achieved.

Demographics

Indicator	Baseline	Current Data
1. Population 0-19 years of age	**1 009 424** (1997)	**1 023 258** (1998)
2. Population of children age 0 - 14 years age 15-24 years who are of Aboriginal origin	 **60 700** **36 700** (1996)	 **60 200** **40 900** (1998)

NOTES ON INDICATORS

[redacted]

Definition
Total BC population under 19 years of age.

Source
BC Statistics, 1998

[redacted]

Definition
Calculated according to 1996 Census data

Source
Statistics Canada, 1996 Census

Comments
1996 Census population data were used because more recent data on persons of Aboriginal origin were not available. Figure may be distorted by the BC share of residents of 77 First Nations reserves and settlements which were not enumerated in the 1996 Census.

Economic Security

Indicator	Baseline	Current Data
1. Percentage of families living above the low income cut-off	**86.8%** (1995)	**86.2%** (1997)
2. Percentage of children age 0-17 years living above the low income cut-off	**79.5%** (1995)	**80.4%** (1997)
3. Unemployment rate (age 15+) Youth unemployment rate (15-24)	**10.6** **20.6** (January 1997)	**8.4** **16.0** (May 1999)

NOTES ON INDICATORS

1. [illegible]

Definition
Refers to economic family units living above the 1992 low-income cut-off as defined by Statistics Canada. LICOs are determined by amount of income used for necessities, family size, degree of urbanization and change according to the Consumer Price Index.

Source
BC Statistics, 1997

2. [illegible]

Definition
Includes all children under 18 years of age in families living above the 1992 low income cut-off as defined by Statistics Canada. LICOs are determined by amount of income used for necessities, family size, degree of urbanization and change according to the Consumer Price Index.

Source
BC Statistics, 1997

3. [illegible]

Definition
The employment rate is calculated as employment as a percent of the working age population.

Source
Statistics Canada.

Housing

Indicator	Baseline	Current Data
1. Percent of renter households in core housing need	**32.5%** (1995)	**30.6%** (1996)
2. Number of households on waiting list for subsidized housing	**10 509** (January 1998)	**10 485** (March 1999)

NOTES ON INDICATORS

1. [illegible]

Definition
Refers to renter core housing need. The average income for these households was $17 500, compared to $46 700 for households not in need.

Source
Ministry of Social Development and Economic Development, Housing Policy Section.

2. [illegible]

Definition
Households on BC Housing's waiting lists.

Source
BC Housing Management.

Child Care

Indicator	Baseline	Current Data
1. Number of licensed day care spaces per 100 children age 0 - 5 years	**15.1** (1995)	**20.8** (February 1998)

NOTES ON INDICATORS

1. Licensed day care spaces

Definition
Includes government approved day care spaces available for every 100 children under years old.

Source
Ministry of Health, Health Planning Database; Ministry for Children and Families, Child Care Services Team.

Service Use

Indicator	Baseline	Current Data
1. Hospital admissions per 1,000 population 0-4 years 5-14 years 15-19 years	 **78.8** **28.0** **58.9** (1996-97)	 **76.49** **27.53** **56.67** (1998)
2. Rate of children and youth under 19 years not living with parents and receiving income assistance per 1,000 total population this age	**2** (1997)	**2** (December 1998)
3. Rate of incarceration per 10,000 youth (12-17 years)	**13.3** (1996-97)	**12.5** (1997-98)

NOTES ON INDICATORS

1. Hospital admissions

Definition
Total number of hospital admissions per 1000 population for 0-4 years, 5-14 years and 15-19 years, age standardized.

Source
Ministry of Health, Information and Analysis Branch.

2. Children and youth not living at home and receiving income assistance

Definition
Represents the number of children receiving basic BC Benefits as a percent of total children under 19. Youth Works and Welfare to Work participants are included in these figures. Aboriginal people living on reserve, persons with a disability and persons living with a relative are not included.

Source
BC Statistics.

3. Youth incarceration
Definition
Includes youth 12-17 years incarcerated as a rate per 10 000 population.

Source
Canadian Centre for Justice Statistics.

APPENDIX B

Changes Since the First Edition of *Measuring Our Success*

There have been three major changes to the *Population Outcomes Framework* since it was initially released in 1997. These are:

1. All indicators for which there were no data or only one-year of data available have been deliberately excluded from the *Framework* as they do not allow for trend analysis. The indicators that have been dropped are:

    - percentage of children and youth with low self-esteem;
    - percentage of youth who can talk to their mothers and fathers openly;
    - percentage of children and youth with a disability attending school or being tutored;
    - percentage of youth with a disability who are generally happy;
    - percentage of youth with a disability who A) do not feel lonely or remote; or B) feel lonely or remote only sometimes;
    - percentage of youth with a disability able to take part in physical activities;
    - percentage of youth with a disability who would like to be more active;
    - rate of victimization among children and youth for violent offences;
    - percentage of adults with developmental disabilities who experience community placement breakdowns;
    - percentage of adults with developmental disabilities satisfied with community living arrangements;
    - percentage of adults with developmental disabilities who are employed;
    - percentage of adults with developmental disabilities who participate in volunteer activity; and,
    - percentage of adults with developmental disabilities satisfied with social relationships.

The decision to eliminate these indicators resulted in two outcome objectives which appeared in the initial *Framework*, having absolutely no indicators on which to report in this edition. The outcome objectives are: (1) *to optimize the health and well being of children and youth with disabilities*; and, (2) *to increase the participation of adults with developmental disabilities in the community*. Consequently, these outcome objectives are not presented in this report. The elimination of these outcome objectives and indicators does not mean that they are not of interest to the ministry. Nor does it mean that they are not worth monitoring. It simply means that at the time of publication, there was no identified data source for monitoring performance in these areas over time. The lack of population level data on both children with disabilities and adults with developmental disabilities are particularly noteworthy.

It is anticipated that as the *Framework* is reviewed in the proposed Performance Management Forums that attention will be directed towards identifying data sources that allow for the monitoring of performance in relation to these outcome objectives and indicators.

2. Provincial performance data have, in a few instances, changed since the first edition. This occurs when the data were erroneously reported in the 1st edition, when it was preliminary in the 1st edition, or when the data changed due to more up to date population statistics.

3. A few new indicators have been added to the *Framework*. They are italicized within the tables and include:
    - rate of sudden infant death syndrome;
    - rate of AIDS contraction among youth;
    - percentage of children exhibiting emotional distress;
    - percentage of children whose parents report harmonious parent/child relations; and
    - percentage of children whose parents report their children get along with peers.

APPENDIX C

Data Sources

The Ministry of Children and Families strives to provide accurate and reliable data. The majority of data contained in this report have been obtained from surveys, published studies or provincial databases. Each data source has implications for the continued maintenance of the *Population Outcomes Framework*. It is anticipated that as the Framework is implemented, the accuracy and completeness of the data will improve over time.

SURVEYS

A survey is a data collection technique that asks questions of respondents. While many of the surveys used in the Framework have published reports which summarize the results, it is often necessary to request the analysis of specific variables to obtain meaningful provincial or benchmark data.

Provincial Surveys

The Framework draws provincial data from one survey.

- *Adolescent Health Survey*, McCreary Centre Society (1993, 1998)

National and Inter-Provincial Surveys

The Framework draws provincial data and benchmark data from five surveys undertaken at the national, or inter-provincial level:

- *National Longitudinal Survey of Children and Youth* (1994, 1996)
- *National Population Health Survey* (1994)
- School Achievements Indicators Program (1993, 1994, 1996)
- Canadian Census (1991, 1996)
- Canada's Health Promotion Survey (1990)

These data sources are longitudinal and, theoretically, will provide information on the same variables over time. The cycle for data collection varies from two to five years. Timeliness is an issue with some of the data obtained from these sources. It should be noted that unless the surveys were specifically designed to ensure provincial representation, such as the School Achievements Indicators Program and the Canadian Census, interpretation of data at the provincial level could be problematic.

International Surveys

The Framework draws benchmark data from one survey undertaken at the international level:

- *Health of Youth*, World Health Organization, European Region (1996)

It is an appropriate source for benchmarks as all the data are gathered from developed countries. There is an intention to repeat the survey every four years.

REPORTS

The Framework relies heavily on publications, which draw their data from either operational data, and/or from a variety of secondary sources. The publications that draw heavily upon operational data are used for provincial data in the Framework and will allow performance to be monitored on an annual fiscal or calendar basis. It should be noted that these data are not immediately available at year-end. Operational data are collected by local health area and aggregated at the regional and provincial level. The reports include:

- *Selected Vital Statistics Indicators and Health Status Indicators, Annual Report 1995, 1996, 1997 and 1998* (plus subsequent *Quarterly Digests)*, Division of Vital Statistics, BC Ministry of Health and Ministry Responsible for Seniors
- *Sexually Transmitted Disease Control, Annual Report 1994, 1995 and 1996* (plus subsequent *AIDS Update Quarterly Reports*), Centre for Disease Control Society, BC Ministry of Health and Ministry Responsible for Seniors
- *Administrative Circulars*, BC Ministry of Health and Ministry Responsible for Seniors
- *AIDS in Canada: Quarterly Surveillance Update*, Health Canada
- *HIV in Canada: Surveillance Report for the period 1985-1995*, Health Canada (1996)
- *Juristat*, Canadian Centre for Justice Statistics, Statistics Canada, Cat 85-002

Published reports that rely primarily on the collection of data from secondary sources were used for benchmarks. These sources provide inter-provincial or international comparisons. They vary in both the frequency of collection and the timeliness of the data.

- *A Report on the Health of British Columbians, Provincial Health Officer's Annual Report 1996*, BC Ministry of Health and Ministry Responsible for Seniors (1997)
- *A Report on the Health and Well-Being of B.C's Children, Provincial Health Officer's Annual Report 1997*, BC Ministry of Health and Ministry Responsible for Seniors (1998)
- *Report on the Health of Canadians*, Federal/Provincial/Territorial Advisory Committee on Population Health (1996)
- *The Progress of Canada's Children 1996 and 1997*, Canadian Council on Social Development
- *Nutrition for Health: An Agenda for Action* (1996)
- *The Health of Canada's Children*, Canadian Institute of Child Health (1994)
- *Profiling Canada's Families*, The Vanier Institute (1994)
- *The Health of Canada's Youth*, Health and Welfare Canada (1992)
- *The State of the World's Children 1996*, UNICEF
- *Causes of Death*, Statistics Canada
- *Poverty Profile 1995*, National Council of Welfare (1997)
- *Oregon Benchmarks 1995 and 1996*, Oregon Progress Board
- *Canadian Profile: Alcohol, Tobacco and Other Drugs, 1997*, Canadian Centre on Substance Abuse/Addiction Research Foundation of Ontario
- *Measuring Up: A Health Surveillance Update on Canadian Children and Youth*, Laboratory Centre for Disease Control, Health Canada (1999)

DATABASES

Databases housed within various BC provincial ministries were used as sources of baseline data and continue to be useful for performance monitoring at the provincial level. It should be noted that most of the data from these sources were not in the required format and needed specific analysis. While some of the sources can provide up-to-date information upon request, most cannot. As these data represent operational data or a collation of data from other sources, there is generally a delay between the occurrence of an activity and when it is recorded in the database.

- Health Data, Warehouse, Ministry of Health
- Health Planning Data Base, Ministry of Health
- BC Vital Statistics, Ministry of Health
- Regional Performance Analysis, Ministry of Health
- Inpatient Services, Ministry of Health
- Injury and Prevention, Office of Injury Prevention, Ministry of Health
- Health Status Registry, BC Vital Statistics Agency, Ministry of Health
- Social Worker System - Management Information Systems (SWS - MIS), Ministry for Children and Families
- Uniform Crime Reporting Survey, Ministry of Attorney General
- BC Centre for Disease Control Society, Ministry of Health
- BC Statistics and Statistics Canada also provided access to data.

APPENDIX D

Annually Updated Indicators by Data Sources

1.1.1	Infant mortality rate	BC Vital Statistics
1.1.2	Rate of low birth rate babies	BC Vital Statistics
1.1.4	Number of newborns born with FAS or drug withdrawal syndrome or noxious influences transmitted to placenta	BC Vital Statistics
1.1.5	Number of infants testing positive for HIV	Ministry of Health, BC Centre for Disease Control Society
1.1.6	Rate of neural tube defects	BC Vital Statistics

1.2.1	Mortality rate for children age 1-4 years	BC Vital Statistics

1.3.1	Mortality rate for children age 5-14 years	BC Vital Statistics
1.3.12	Percentage of young children caries immune	Ministry of Health, Dental Program

1.4.1	Mortality rate for youth	BC Vital Statistics
1.4.2	Sexually transmitted disease rates for youth	Ministry of Health, BC Centre for Disease Control Society
1.4.3	Rate of HIV infection among youth	Ministry of Health, BC Centre for Disease Control Society
1.4.4	Rate of AIDS contraction among youth	Ministry of Health, BC Centre for Disease Control
1.4.9	Percentage of students completing high school	Ministry of Education

1.6.1	Teen pregnancy rate	BC Vital Statistics
1.6.2	Teen birth rate	BC Vital Statistics

1.7.3	Rate of direct and indirect alcohol-related death among children and youth	BC Vital Statistics
1.7.4	Rate of drug-induced death among children and youth	BC Vital Statistics

1.8.1	Rate of direct and indirect alcohol-related death among adults	BC Vital Statistics
1.8.2	Rate of drug-induced deaths among adults	BC Vital Statistics

1.9.1	Suicide rate for children and youth	BC Vital Statistics

2.1.1	Rate of domestic child abuse/neglect	Ministry for Children and Families, SWS-MIS statistical extract files*
2.1.3	Rate of children and youth charged with prostitution-related offenses	Ministry of the Attorney General, Police Services Division, Uniform Crime Reporting Survey

2.2.1	Percentage of 2 year olds properly immunized for; Diptheria/Tetanus, Pertussis, Polio, Haemophilus Influenza B, Measles, Mumps And Rubella	Ministry of Health, Public Health Nursing, B.C.
2.2.2	Percentage of kindergarten (school entry) children immunized for; Diptheria/Tetanus, Polio, Measles, Mumps And Rubella	Ministry of Health, Public Health Nursing, B.C.
2.2.3	Percentage of grade 6 students immunized for Hepatitis B	Ministry of Health, Public Health Nursing, B.C.
2.2.4	Rate of vaccine-preventable diseases for Diptheria, Tetanus, Pertussis, Polio, Haemophilus Influenza B, Measles, Mumps, Rubella, Hepatitis B	BC Centre for Disease Control Society

2.3.1	Rate of a) death and b) hospitalization of children and youth due to unintentional injuries	a) BC Vital Statistics b) Ministry of Health, Office of Injury Prevention
2.3.2	Rate of a) death and b) hospitalization of children and youth due to transportation-related injuries	a) BC Vital Statistics b) Ministry of Health, Office of Injury Prevention
2.3.3	Rate of a) death and b) hospitalization of children and youth due to fire-related injuries	a) BC Vital Statistics b) Ministry of Health, Office of Injury Prevention
2.3.4	Rate of a) death and b) hospitalization of children and youth due to water-related injuries	a) BC Vital Statistics b) Ministry of Health, Office of Injury Prevention
2.3.5	Rate of a) death and b) hospitalization of children and youth due to home/residential injuries	a) BC Vital Statistics b) Ministry of Health, Office of Injury Prevention

3.1.1	Average length of stay of adults with developmental or multiple disabilities in tertiary care facilities	Ministry for Children and Families, Willow Clinic

4.1.1	Rate of youth charged with violent offenses	Statistics Canada, Youth Court Statistics
4.1.2	Percent of youth offenders admitted to custody and community supervision who are repeat offenders	Ministry of the Attorney General, Corrections Branch

APPENDIX E

Regional Data Sources

1.1.1	Infant mortality rate	BC Vital Statistics
1.1.2	Rate of low birth weight babies	BC Vital Statistics
1.1.4	Number of newborns with FAS or drug withdrawal syndrome or noxious influences transmitted to placenta	BC Vital Statistics
1.1.5	Number of infants testing positive for HIV	BC Centre for Disease Control Society
1.1.6	Rate of neural tube defects	BC Vital Statistics
1.1.7	Number of SIDS deaths	BC Vital Statistics

1.2.1	Mortality rate for children age 1-4 years	BC Vital Statistics

1.3.1	Mortality rate for children age 5-14 years	BC Vital Statistics
1.3.8	Percentage of children doing well in math problem solving and math knowledge	Council of Ministers of Education, Report on Mathematics Assessment
1.3.9	Percentage of children doing well in reading and writing	Council of Ministers of Education, Report on Reading and Writing Assessment
1.3.10	Percentage of children taking part in physical activity	McCreary Centre, *Adolescent Health Survey*
1.3.12	Percentage of young children caries immune	Ministry of Health, Dental Program

1.4.1	Mortality rate for youth	BC Vital Statistics
1.4.2	Sexually transmitted disease rate for youth	BC Centre for Disease Control Society
1.4.3	Rate of HIV infection among youth	BC Centre for Disease Control Society
1.4.4	Rate of AIDS contraction among youth	BC Centre for Disease Control Society
1.4.7	Percentage of youth doing well in math problem solving and math knowledge	Ministry of Education, Report on Mathematics Assessment
1.4.8	Percentage of youth doing well in reading and writing	Ministry of Education, Report on Reading and Writing Assessment
1.4.9	Percentage of students completing high school	Ministry of Education, Annual Report
1.4.10	Percentage of youth taking part in physical activity	McCreary Centre, *Adolescent Health Survey*
1.4.11	Percentage of students who want to lose weight	McCreary Centre, *Adolescent Health Survey*

1.6.1	Teen pregnancy rate	BC Vital Statistics
1.6.2	Teen birth rate	BC Vital Statistics
1.6.3	Percentage of sexually active females using contraception	McCreary Centre, *Adolescent Health Survey*

1.7.1	Percentage of children and youth who smoke	McCreary Centre, *Adolescent Health Survey*
1.7.2	Percentage of students who drink alcohol regularly	McCreary Centre, *Adolescent Health Survey*

1.7.3	Rate of direct and indirect alcohol-related death among children and youth	BC Vital Statistics
1.7.4	Rate of drug-induced death among children and youth	BC Vital Statistics

1.8.1	Rate of direct and indirect alcohol-related death among adults	BC Vital Statistics
1.8.2	Rate of drug-induced death among adults	BC Vital Statistics

1.9.1	Suicide rate for children and youth	BC Vital Statistics
1.9.2	Percentage of students attempting suicide	McCreary Centre, *Adolescent Health Survey*
1.9.3	Percentage of students considering suicide	McCreary Centre, *Adolescent Health Survey*

2.1.1	Rate of domestic child abuse/neglect	Ministry for Children and Families, SWS/MIS files
2.1.2	Percentage of students who have been physically and/or sexually abused	McCreary Centre, *Adolescent Health Survey*
2.1.3	Rate of children and youth charged with prostitution-related offenses	Ministry of the Attorney General, Police Services Division

2.2.1	Percentage of 2 year olds properly immunized for; diptheria/tetanus, pertussis, polio, haemophilus influenza B, measles, mumps and rubella	Public Health Nursing, B.C., Ministry of Health
2.2.2	Percentage of kindergarten (school entry) children immunized for; diptheria/tetanus, polio, measles, mumps and rubella	Public Health Nursing, B.C., Ministry of Health
2.2.3	Percentage of grade 6 students immunized for hepatitis B	Public Health Nursing, B.C., Ministry of Health
2.2.4	Rate of vaccine-preventable diseases for diptheria, tetanus, pertussis, polio, haemophilus influenza B, measles, mumps, rubella, hepatitis B (acute/undetermined and carrier/chronic)	BC Centre for Disease Control Society

2.3.1	Rate of a) death and b) hospitalization of children and youth due to unintentional injuries	a) BC Vital Statistics b) Ministry of Health, Office of Injury Prevention
2.3.2	Rate of a) death and b) hospitalization of children and youth due to transportation-related injuries	a) BC Vital Statistics b) Ministry of Health, Office of Injury Prevention

2.3.3	Rate of a) death and b) hospitalization of children and youth due to fire-related injuries	a) BC Vital Statistics b) Ministry of Health, Office of Injury Prevention
2.3.4	Rate of a) death and b) hospitalization of children and youth due to water-related injuries	a) BC Vital Statistics b) Ministry of Health, Office of Injury Prevention
2.3.5	Rate of a) death and b) hospitalization of children and youth due to horr e/residential injuries	a) BC Vital Statistics b) Ministry of Health, Office of Injury Prevention

4.1.1	Rate of youth diverted from criminal justice system through police-based and formal diversion	Ministry of the Attorney General, Police Services Division and Corrections Branch
4.1.2	Percent of youth offenders admitted to custody and community supervision who are repeat offenders	Ministry of the Attorney General, Police Services Division

***Measuring Our Success* Feedback Form**

We would like to hear from you, our readers, so that we can maximize the usefulness of this document for planning future editions. Please fill in the following form to let us know how you think we are doing and where improvements can be made. Thank you in advance for your input.

Unless otherwise indicated, please circle the letter to the left of the response.

1. How have you used this edition of *Measuring our Success*?
   a) I have not used it yet
   b) information only
   c) trend identification
   d) other (please specify)

_____

_____

2. In general, how comprehensive do you find the collection of outcome indicators for your line of work?

   a) Very b) Somewhat c) Indifferent d) Not Very e) Not at All

3. Please identify additional indicators and possible data sources that would be useful to include in the future reports.

Outcome Objective #	Additional Indicator	Source of Indicator (if possible)

4. What type of information are you most interested in finding in this report?

_____

_____

_____

5. How useful did you find the indicators?

   a) Very b) Somewhat c) Indifferent d) Not Very e) Not at All

6. What type of benchmark do you think would be most useful?
   a) jurisdictional best performance based on regional standards
   b) jurisdictional best performance based on national standards
   c) jurisdictional best performance based on international standards
   d) other (please specify) _____

7. Should the benchmarks change over time?

   ☐ Yes ☐ No

8. How would you rate the following aspects of this report?

	Excellent		OK		Poor
a) ease of finding information	1	2	3	4	5
b) organization / layout	1	2	3	4	5
c) presentation / appearance	1	2	3	4	5
d) overall length	1	2	3	4	5
e) content	1	2	3	4	5
f) clarity of purpose	1	2	3	4	5
g) indicators/measures used	1	2	3	4	5

8. Please use the following space to provide comments about improving the content and/or presentation of the report.

_____

_____

_____

9. What area(s) do you work in?
   a) Ministry for Children and Families
   b) other ministry in the BC government (please specify)_____
   c) municipal government
   d) federal government
   e) Regional Health Board/ Community Health Board
   f) school board
   g) community service agency
   h) academic
   i) medical
   j) other (please specify) _____

11. What is your job function?
   a) managerial
   b) program delivery
   c) research
   d) policy development
   e) other (please specify)_____

Optional Information

Please provide the following information if you wish to be kept informed about the review of the *Population Outcomes Framework.*

Name: _____
Position: _____
Address: _____
_____

Email: _____

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